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ABSTRACT

The State Children's Health Insurance Program (SCHIP) provides funds to states to expand health insurance coverage for low-income children who are uninsured. States have a great deal of flexibility to design and implement SCHIP, resulting in considerable diversity across states. Enrollment reached 3.4 million in federal fiscal year 2000 and continued to climb to 4.6 million in 2001. This report describes the early implementation and progress of SCHIP programs in reaching and enrolling eligible children and reducing the number of low-income children who are uninsured. The report presents a snapshot of states' early experiences with their SCHIP programs based on information from state evaluations submitted in March, 2000, prior to modifications made to take advantage of the flexibility offered under the Social Security Act Title XXI statutes governing the Children's Health Insurance Program. Following a discussion of the background and rationale for the report, the report details the following: (1) factors affecting the provision of health insurance to low-income children; (2) SCHIP eligibility criteria and policies; (3) scope of benefits and cost-sharing requirements; (4) states' choice of delivery systems to serve SCHIP enrollees; (5) coordination between SCHIP and other public programs; (6) states' reflections on the effectiveness of their SCHIP outreach efforts; (7) how states are avoiding crowd-out of private insurance; (8) state progress toward reducing the number of uninsured low-income children; and (9) state recommendations for improving Title XXI. The report's three appendices include a profile of SCHIP programs in the U.S. territories, a summary of amendments to Title XXI state plans as of March, 2001, and supplemental information on benefit design and cost-sharing structure of SCHIP programs. (Contains 34 references.) (HTH)

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Background for the Report to Congress

March 2003

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EXECUTIVE SUMMARY

The State Children's Health Insurance Program (SCHIP) provides funds to states to expand health insurance coverage for low-income children who are uninsured. States have a great deal of flexibility to design and implement SCHIP, resulting in considerable diversity across states. Moreover, SCHIP programs continue to grow and evolve, with state approaches being modified and expanded as states gain experience and knowledge. Enrollment in SCHIP more than doubled from one million children in Federal fiscal year (FFY) 1998, to two million children during FFY 1999. Enrollment reached 3.4 million in FFY 2000 and continued to climb to 4.6 million in FFY 2001.[1]

This report describes the early implementation and progress of SCHIP programs in reaching and enrolling eligible children and reducing the number of low-income children who are uninsured. The report presents a snapshot of states' early experiences with their SCHIP programs based on information contained within the state evaluations, which were submitted in March 2000. SCHIP is a dynamic program and many states have modified their SCHIP programs to take advantage of the flexibility offered under title XXI. This report, therefore, provides a snapshot of SCHIP in its early years.

I. BACKGROUND FOR THIS REPORT

Congress mandated that states evaluate the effectiveness of their SCHIP programs and submit a report to the Centers for Medicare & Medicaid Services (CMS) by March 31, 2000.[2] Congress further required that the Secretary of the Department of Health and Human Services (DHHS) submit a report to Congress by December 31, 2001, based on the states' evaluations. Recognizing these statutory requirements—as well as the need for more in-depth assessment of the performance of SCHIP programs—CMS contracted with Mathematica Policy Research, Inc. (MPR) to conduct a national evaluation of SCHIP,[3] which included summarizing the findings and recommendations from the state evaluations. This report provides background for the DHHS Secretary's Report to Congress.

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[1] In addition, three states (New Jersey, Rhode Island, and Wisconsin) used title XXI funds to cover 233,000 adults in FFY 2001.

[2] The Centers for Medicare & Medicaid Services was formerly the Health Care Financing Administration (HCFA).

[3] The Balanced Budget Refinement Act of 1999 (BBRA) appropriated additional funds for the evaluation of SCHIP. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) oversees a separate study of 10 states, including a survey of the target population. The Secretary is submitting a separate report, as mandated under BBRA.

To assist states in evaluating their programs, the National Academy for State Health Policy (NASHP) convened a workgroup of state and Federal officials, policymakers, and researchers to develop a standardized framework that states could use to prepare their evaluations. The framework was intended to facilitate cross-state comparison, based on a common structure and format. In addition, the framework was designed to accommodate the diversity of state approaches to providing health insurance coverage and to allow states flexibility in highlighting their key accomplishments and progress (NASHP 1999).

The state evaluations provided a snapshot of the features and activities of SCHIP programs as of March 2000. However, given that states have used the flexibility allowed under title XXI to continue to adapt their SCHIP programs to meet the needs in their state, some of the information contained in this report may no longer be accurate.

The majority of the evidence presented in the state evaluations is descriptive in nature. Given the short timeframe between implementation and evaluation, most states had limited ability to gather quantitative information by the time that they submitted their evaluations.

II. FACTORS AFFECTING THE PROVISION OF HEALTH INSURANCE TO LOW-INCOME CHILDREN

More than half the states implemented SCHIP in the context of preexisting, non-Medicaid health care programs. Of the 27 states with preexisting programs, one-third discontinued their programs and transferred enrollees to SCHIP, while two-thirds continued to serve children who were ineligible for Medicaid or SCHIP. States with preexisting programs were more likely to implement S-SCHIP programs.

Since the implementation of SCHIP, states reported many other changes that took place, which may affect the availability, affordability, and quality of children's health coverage.

- Thirty-nine states and the District of Columbia reported changes to their traditional Medicaid programs. The most common changes—easing of documentation requirements and elimination of face-to-face interviews—were designed to streamline the eligibility determination process and minimize barriers to enrolling in Medicaid.

- Thirty-seven states indicated that changes had taken place in the private insurance market, most often citing health insurance premium rate increases. Many states expressed concerned about the stability of the market, especially as the economy slows.

- Thirty-three states reported that welfare reform affected health coverage of children, primarily resulting in reductions in their Medicaid caseloads. States reported that some of the early declines in Medicaid coverage have been curtailed as a result of eligibility expansions and enhanced outreach under SCHIP, as well as efforts to reinstate coverage among Medicaid-eligible children whose coverage was inappropriately terminated.

Some of these changes may foster the availability and accessibility of insurance coverage (such as changes in the Medicaid enrollment process), while others may reduce the likelihood of coverage (such as private health insurance premium increases). It is important to recognize that these changes may have complex interactions with the availability and source of health insurance coverage for low-income children; however, their precise effects are difficult to quantify and isolate in evaluations of SCHIP.

III. SCHIP ELIGIBILITY CRITERIA AND POLICIES

States took advantage of the considerable flexibility offered by title XXI to design their SCHIP eligibility criteria and policies so that they responded to local needs. Title XXI authorized states to establish income eligibility thresholds for SCHIP up to 200 percent of poverty, or 50 percentage points above the Medicaid thresholds in effect on March 31, 1997. States were able to set SCHIP thresholds above these limits through the use of income disregards, and several states have received approval to do so. States that used a net-income test in determining eligibility effectively raised the eligibility threshold by disregarding certain types of income. Forty-four states used net-income tests in one or more of their SCHIP programs. Few states required asset tests under SCHIP, in an effort to streamline the eligibility determination process.

As of March 31, 2001, 16 states had set thresholds below 200 percent of poverty; 25 states had established SCHIP eligibility at 200 percent of poverty, and the remaining 10 states had set eligibility thresholds above 200 percent of poverty. The average SCHIP state income threshold, as of March 31, 2001, was 206 percent of poverty. Title XXI permits states to amend their programs as needed. Since implementation, 23 states have raised their SCHIP eligibility thresholds: 14 expanded eligibility within an existing SCHIP program; 5 phased in an S-SCHIP component after initially implementing an M-SCHIP component; and 4 used both approaches to expand eligibility.

The level of coverage expansion brought about by SCHIP is a function, not only of the upper income eligibility for SCHIP, but also the "floor" where Medicaid coverage stops and SCHIP coverage begins. On average, SCHIP raised income thresholds by 61 percentage points among children ages 1 through 5, but among older adolescents (ages 17 and 18), SCHIP expanded coverage by an average of 129 percentage points. Equally important, SCHIP has enabled states to minimize the impact of the traditional "stair-step" approach to eligibility under Medicaid that, in most states, left some children within a low-income family without coverage.

Most states have implemented policies to improve the continuity of coverage, such as provisions for 12-month continuous eligibility and annual redeterminations.

- Twenty-nine states used annual redeterminations and offered 12 months of continuous eligibility (although this coverage was not extended to all children enrolled in SCHIP in eight of these states).

- Fifteen states redetermined eligibility annually, but had less generous policies related to continuous eligibility. Four of these states provided six months of continuous eligibility, while the other 11 provided no guarantee of continuous eligibility.

- Only 7 states determined eligibility more frequently than every 12 months.

State eligibility policies continue to evolve. In addition to covering children, states have expressed an interest in using SCHIP funds to cover adult populations. Six states have received approval under SCHIP Section 1115 demonstrations to cover adults under SCHIP. It remains to be seen whether slowdowns in the economy will have any impact on states' ability to support SCHIP eligibility expansions in the future.

IV. SCOPE OF BENEFITS AND COST-SHARING REQUIREMENTS

States were given flexibility—within certain constraints—to develop a benefit package consistent with that offered in the public or private insurance markets. The following general patterns were observed:

- All SCHIP programs reported that they offered a core set of benefits, such as inpatient, emergency, and outpatient hospital services, physician services, preventive services (including immunizations), inpatient and outpatient mental health services, X-ray and laboratory services, vision screening, and prescription drug benefits.

- Although S-SCHIP programs were granted more flexibility in the design of their benefit package (relative to traditional Medicaid), most said they covered dental services, corrective lenses, family planning, substance abuse treatment, durable medical equipment (DME), physical, speech, and occupational therapy, and home health services. Some states reported that they chose to augment their benefit packages with these services because of their importance to children's health and development.

- Certain services were less common in S-SCHIP programs than in M-SCHIP programs, such as over-the-counter medications, developmental assessments, rehabilitation services, private duty nursing, personal care, podiatry, and chiropractic services.

- Enabling services—such as case management/care coordination, interpreter services, and non-emergency transportation—were more often covered by M-SCHIP than S-SCHIP programs. These services are generally used to reduce nonfinancial barriers and to facilitate access to care among lower income populations.

- S-SCHIP programs were more likely than M-SCHIP programs to charge premiums, copayments, or enrollment fees, as is permitted by title XXI. S-SCHIP programs generally served higher income populations than M-SCHIP programs and cost-sharing requirements were often viewed as a strategy for preventing the substitution of public for private insurance coverage.

States also had the flexibility to structure benefit limits for specific types of services. For example:

- Fourteen states placed limits on the scope or quantity of preventive dental services, and 18 states placed limits on restorative services. Such limits were more common among S-SCHIP programs than among M-SCHIP programs.
- Twenty S-SCHIP programs had inpatient and/or outpatient mental health benefit limits; 5 M-SCHIP programs had limits on outpatient mental health services.
- Seventeen S-SCHIP and 6 M-SCHIP programs imposed benefit limits on physical, speech, and occupational therapy.

Given the variability and complexity of SCHIP benefits and cost-sharing provisions across states (and even, within states, across programs), it is difficult to grasp all the nuances and discern how the effective level of coverage varies for families. It appears, however, that states have structured their SCHIP cost-sharing requirements for covered services to assure that families do not exceed the 5 percent cap, as required under title XXI.

V. STATES' CHOICE OF DELIVERY SYSTEMS TO SERVE SCHIP ENROLLEES

Title XXI allowed states considerable flexibility in designing a delivery system to serve SCHIP enrollees. As a result, SCHIP programs used a variety of approaches to deliver and pay for services, including traditional fee-for-service (FFS); primary care case management (PCCM), where care is managed by a designated primary care physician; and managed care with capitated payments. Many states also chose to carve out certain types of benefits and deliver them through a separate system. States reported that their choice of delivery system and use of carve-outs for certain benefits was based on several factors, including ease of implementation, costs, and conditions specified in state legislation.

Due to a variety of circumstances, managed care was not the dominant delivery system among SCHIP programs.

- Although 43 states had a managed care delivery system in place, it was the dominant system in 20 states, and the sole system in 8 states.[4]
- PCCM and FFS delivery systems played a dominant role in serving SCHIP enrollees in 14 states. In many of these states, managed care generally was not well established in smaller urban and rural areas.
- Seventeen states used a mix of delivery systems so that no one system dominated. In 9 of the 17 states, one type of system was used for the M-SCHIP component and another for the S-SCHIP component.

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[4] A dominant delivery system was defined as one that enrolled at least two-thirds of SCHIP enrollees; otherwise, the delivery system was considered a "mixed" system. The designation was based on data from the SCHIP Statistical Enrollment Data System for the fourth quarter of Federal fiscal year 2000.

- All M-SCHIP components relied on the Medicaid delivery system to serve their SCHIP enrollees; 16 of the 34 S-SCHIP programs used it as well. The remaining S-SCHIP programs established delivery systems separate from Medicaid. States reported that their Medicaid and S-SCHIP programs often attracted the same providers, facilitating continuity of care when children transferred between programs due to changes in family circumstances or when families had children in more than one program.

- Thirty-one states carved out at least one type of service, and most paid for carved-out services on a fee-for-service basis. Twenty-two states carved out behavioral health services and 15 states carved out dental services.

Many states reported that they faced challenges in establishing and maintaining provider networks, regardless of the type of delivery system that was used. These challenges included providing families with a choice of health plans and ensuring an adequate number of providers. Based on the state evaluations, it appeared that many states were proactive in meeting the challenges they faced in developing and maintaining their delivery systems. State efforts included monitoring network capacity, encouraging participation of safety net providers, and improving health plan and provider participation. Nevertheless, instability in the health care marketplace may continue to present challenges to SCHIP programs and their ability to meet the needs of enrollees and their families. Some specific concerns expressed by states were chronic shortages of dental and vision providers, and gaps in provider networks in rural areas. Most states reported that they plan to gather consumers' assessments of their health plans and providers to gain a better understanding of how well SCHIP delivery systems are meeting enrollees' needs.

VI. COORDINATION BETWEEN SCHIP AND OTHER PUBLIC PROGRAMS

Successful coordination between SCHIP and other public programs—such as Medicaid, title V Maternal and Child Health (MCH) programs, the National School Lunch Program (NSLP), or the Special Supplemental Food Program for Women, Infants, and Children (WIC)—can contribute to a state's ability to provide health insurance coverage to as many uninsured, low-income children as possible. Effective coordination can also help avoid the confusion on the part of the general public that may result from having multiple programs that assist low-income families.

All states with S-SCHIP programs coordinated with Medicaid programs in multiple ways.[5]

- ***Outreach***. Twenty-six of the 30 states with S-SCHIP programs reported that they coordinated outreach with Medicaid, such as marketing the programs under a single name, using the same eligibility staff for both programs, or providing assistance in filling out applications.

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[5] This analysis was based on the 30 states with S-SCHIP programs at the time the state evaluations were submitted.

- ***Joint Applications***. Twenty-five of the 30 states with S-SCHIP programs reported that they used a joint application with Medicaid, which allowed states to streamline eligibility determination.

- ***Administration***. Twenty-five of the 30 states with S-SCHIP programs reported that they coordinated administration between the two programs, in an effort to minimize administrative costs and make the programs seamless to families.

- ***Data Collection and Quality Assurance***. Twenty-five of the 30 states with S-SCHIP programs reported that they coordinated data collection, and 24 reported that they coordinated quality assurance, in an effort to minimize the paperwork burden on providers and facilitate analysis of enrollment, access, and utilization patterns.

- ***Service Delivery, Contracts, and Procurement***. States were slightly less likely to coordinate service delivery (23 states), contracts (19 states), or procurement efforts (18 states) between their S-SCHIP and traditional Medicaid programs.

Most states also coordinated with title V MCH programs, but less than half coordinated with schools or school lunch programs or the WIC program. The most common form of coordination was outreach. States appear to have focused less attention on coordinating their eligibility determination, service delivery, and monitoring/evaluation activities. As states continue to search for ways to reach children who are eligible for SCHIP but who remain uninsured (or become uninsured due to changes in family circumstances), enhanced coordination with other public programs may hold promise for the future.

VII. STATES' REFLECTIONS ON THE EFFECTIVENESS OF THEIR SCHIP OUTREACH EFFORTS

State outreach efforts have been an important factor in raising awareness about enrolling eligible children in SCHIP and Medicaid. Since the implementation of SCHIP, states have placed an emphasis on "reaching out" to eligible children and their families to inform them about Medicaid and SCHIP, answer their questions, and help them enroll in the appropriate program. Evidence on the large proportion of uninsured children who are potentially eligible for Medicaid but not enrolled reinforced the need for effective outreach for SCHIP, as well as Medicaid.

To reach diverse populations, most states combined state-level, mass-media campaigns with local-level, in-person outreach. Statewide media advertising built awareness of the program, while local-level outreach provided "points of entry" where families could obtain in-depth program information and receive application assistance.

- ***Outreach Activities.*** Almost all states promoted SCHIP using a hotline, brochures or flyers, radio/television/newspaper ads, public service announcements, signs or posters, education sessions, or direct mail. Between one-half and two-thirds used nontraditional hours for application intake, public access or cable television programming, home visits, or public transportation ads. Fewer than half used billboards, phone calls by state staff or brokers, or incentives for enrollees, outreach staff, or insurance agents.

- ***Outreach Settings.*** Most states conducted outreach in community health centers, public meetings/health fairs, community events, schools or adult education sites, provider locations, social service agencies, day care centers, or faith-based organizations. A majority of states also used libraries, grocery stores, public housing, job training centers, homeless shelters, workplaces, fast food restaurants, or laundromats. States were less likely to use refugee resettlement programs or senior centers as outreach sites.

States assessed the effectiveness of their efforts on a five-point scale (where 1 is least effective and 5 is most effective). States' ratings were based on various types of quantitative and qualitative evidence.[6]

- Personalized outreach activities, such as hotlines and home visits, were rated as more effective than mass-media approaches. Direct mail, incentives for education/outreach staff, signs and posters, public transportation ads, and billboards were rated as the least effective activities.
- The most effective outreach settings, according to state ratings, were provider locations, community health centers, schools and adult education centers, beneficiaries' homes, and social service agencies. The least effective settings were those where health insurance for children would be the least relevant: senior centers, fast food restaurants, libraries, grocery stores, battered women's shelters, and laundromats.

The state evaluations also offered insights into the lessons states have learned in the early years of building the outreach and enrollment infrastructure for their programs.

- ***Building Capacity for Outreach Activities.*** SCHIP spurred states to enhance their capacity for outreach by modifying or creating new partnerships with Federal, state, and community programs and with organizations that served the target population.
- ***Coordinating Outreach Activities.*** State and local outreach efforts required centralization and coordination to ensure consistency in marketing and enrollment assistance.
- ***Training State and Local Partners.*** Many states increased enrollment opportunities for families by training state and local partners—such as providers, school officials, and community-based organizations—to conduct outreach and provide enrollment assistance.
- ***Financing Outreach Activities.*** Title XXI placed a 10 percent limit on Federal matching for administrative expenses under SCHIP. Several states reported foregone outreach opportunities in order to stay within the 10 percent administrative cap.

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[6] The most common sources of information were enrollment trends, hotline statistics, and application data. Other sources included surveys, contractor or agency reports, focus groups, and event data.

Some states, however, found other ways to fund outreach, such as state funds, health plan efforts, foundation grants, and partnerships with other organizations.

From the information reported in the state evaluations, it appears that some states are moving toward conducting more rigorous evaluation of the effectiveness of their outreach activities. A few states, for example, are planning to link enrollment, application, and referral source data to measure the effectiveness of various outreach efforts on actual enrollment.

VIII. HOW STATES ARE AVOIDING CROWD-OUT OF PRIVATE INSURANCE

Title XXI required states to implement procedures to ensure that health insurance coverage through SCHIP did not displace, or crowd out, private coverage. This provision was included because SCHIP targets children with higher incomes than traditional Medicaid and there were concerns that these children might be more likely to have access to, or be covered by, employer-sponsored insurance. Crowd-out may occur when employers or families voluntarily drop existing private coverage in favor of SCHIP. SCHIP may provide two incentives for families to drop existing private coverage: one, SCHIP coverage often has lower costs (that is, premiums and/or copayments) compared to private coverage; and two, it may provide more comprehensive benefits. Employers, too, may face financial incentives to discontinue dependent coverage or reduce their contributions if SCHIP coverage is available for their low-wage workers. (Employers are not permitted to reduce benefit coverage for employees based on their eligibility for a public program.)

States have incorporated a variety of features into their SCHIP programs to prevent crowd-out among applicants. As of March 31, 2000:

- Nearly three-fourths of all states reported that they implemented a waiting period without health insurance coverage. The most common duration is three to six months. All states with eligibility thresholds above 200 percent of poverty have instituted a waiting period.
- About one-third of all states indicated that they designed their benefit package to avoid crowd out.
- Many states implemented crowd-out prevention procedures as part of their eligibility determination process, such as collecting insurance information on the application (41 states), conducting record matches (17 states), and verifying application information with employers (13 states).

The information reported in the state evaluations suggests that states did not perceive crowd-out to be a major problem during the early years of SCHIP. Of the 16 states that presented evidence in their state evaluations, 8 reported that they detected no crowd-out, 5 reported rates of less than 10 percent, and 3 reported rates between 10 and 20 percent. Given the extent of crowd-out prevention and monitoring strategies used by states—especially waiting periods, record matches, and verification checks—most states reported that they were confident that substitution of public for private coverage was minimal.

Although states were almost unanimous in their belief that little or no crowd-out was occurring under SCHIP, the data must be examined carefully, considering the variation from state to state in defining, collecting data on, and monitoring crowd-out. Furthermore, states had limited experience upon which to base the assessments presented in their state evaluations. Ongoing monitoring of crowd-out will be necessary to detect whether substitution is occurring in the future, particularly as states raise their eligibility thresholds above 200 percent of poverty and extend coverage to parents.

IX. STATE PROGRESS TOWARD REDUCING THE NUMBER OF UNINSURED LOW-INCOME CHILDREN

Title XXI required states to track their progress toward reducing the number of uninsured, low-income children. However, this is one of the most elusive outcomes to measure, due to the lack of precise, consistent, and timely data. Moreover, by March 31, 2000, when states were required to submit their evaluations, many SCHIP programs had been operational for only 18 to 24 months, further challenging states' efforts to document their progress.

To facilitate the tracking of state progress, CMS required each state to derive and report a baseline estimate of the number of uninsured, low-income children prior to SCHIP. Thirty states used the CPS to derive their baseline estimate, including 6 that used the three-year averages published by the Census Bureau and 24 that made statistical adjustments to CPS data to compensate for its limitations. Another 15 states opted to produce their baseline estimates based on state-specific surveys. Of the remaining 6 states, 5 did not provide enough detail to determine the primary source or methodology, and 1 did not report a baseline estimate in its state evaluation. State approaches to measuring progress varied, and each approach has important limitations.

- ***Aggregate Enrollment Levels***. Most states used aggregate enrollment in SCHIP to measure state progress. However, because some children may have had other insurance coverage prior to enrolling in SCHIP, enrollment figures may overstate reductions in the number of uninsured children.

- ***Penetration Rates***. Some states derived a penetration rate, measuring enrollment in relation to their baseline uninsured estimate. The penetration rates generally ranged from 30 to 50 percent. However, the methods of calculating penetration rates varied among the states.

- ***Uninsured Rates Over Time***. A few states compared the number or rate of uninsured children before and after SCHIP. None of the states conducted significance testing to determine whether changes over time were statistically significant.

In discussing their progress toward reducing the number of uninsured, low-income children, many states emphasized the spillover effect of SCHIP outreach on the enrollment of eligible children in Medicaid. Some states reported that Medicaid enrollment attributable to SCHIP actually exceeded the level of SCHIP enrollment, indicating that SCHIP may be having a much more dramatic effect on reducing the number of uninsured, low-income children than would be reflected by analysis of SCHIP enrollment patterns alone.

X. STATE RECOMMENDATIONS FOR IMPROVING TITLE XXI

Congress mandated that the state evaluations include recommendations for improving SCHIP. States recommended various changes in coverage, financing, administration, and program orientation, many of which reflected state concerns about the proposed rule for SCHIP.[7] A number of these concerns were addressed by the final rule, revised final rule, and later program guidance. The following recommendations were mentioned most frequently in the state evaluations:

- The most common concern among states was that the 10 percent administrative cap constrained many states' efforts to conduct outreach, particularly among states with S-SCHIP programs that cannot obtain regular Medicaid matching funds for excess expenditures. States offered a number of suggestions, ranging from changing the way the cap is calculated, to removing outreach costs from the cap, to raising the level of the cap.

- When the Notice of Proposed Rulemaking and Final Rule were released, many states perceived a shift in the direction of the title XXI program at the Federal level, signaling less flexibility, particularly for S-SCHIP programs. This concern was motivated by the perception that the SCHIP regulations reflected a Medicaid orientation, which could add to the costs and limit creativity among SCHIP programs. Specifically, states expressed concerns about the more stringent limits on cost sharing for lower-income families, requirements for fraud detection, and requirements to implement consumer protections in managed care programs.

- Many states reported that they faced significant barriers in coordinating with employer-sponsored insurance, an important vehicle for expanding insurance coverage among low-income children and for avoiding crowd-out of private insurance coverage. Areas for improvement included reducing requirements for employer contributions, minimizing waiting periods without health insurance coverage, and easing requirements for health plans (such as benefits and cost-sharing limits).

- Some states suggested that they cannot succeed in reducing the number of uninsured, low-income children until coverage is expanded to certain omitted groups, such as children of public employees, immigrant children, and uninsured parents. In addition, some states suggested extending SCHIP to children with catastrophic coverage only, because they may lack coverage for routine and preventive care.

As the SCHIP program enters its sixth year, states are continuing to strive to meet the goal of reducing the number of uninsured low-income children. These recommendations reflect state priorities for improving the SCHIP program.

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[7] The state evaluations were submitted a few months after the release of the proposed rule for the implementation of SCHIP (*Federal Register*, November 1, 1999). Subsequently, CMS issued the final rule (*Federal Register*, January 11, 2001) and revisions to the final rule (*Federal Register*, June 25, 2001). CMS also released a Dear State SCHIP Director letter on July 31, 2000 that discussed the guidelines for SCHIP 1115 demonstration waiver requests.

I. INTRODUCTION

The State Children's Health Insurance Program (SCHIP) provides funds to states to expand health insurance coverage for low-income children who are uninsured. Congress enacted SCHIP under the Balanced Budget Act of 1997, and created title XXI of the Social Security Act. SCHIP represents the largest expansion of publicly sponsored health insurance coverage since Medicare and Medicaid were established more than three decades ago. This landmark program was enacted at a time when the number and rate of uninsured children were growing, especially among those just above the poverty threshold, who were too poor to purchase private health insurance coverage but not poor enough to qualify for Medicaid. Moreover, there was growing recognition of the large number of uninsured children who were eligible for, but not enrolled in, Medicaid.

A. OVERVIEW OF SCHIP AS OF MARCH 31, 2001

Title XXI gave states the option of designing a separate child health program, providing coverage under a Medicaid expansion, or using a combination of the two approaches. All 50 states and the District of Columbia have implemented SCHIP programs, which are tailored to meet each state's need, context, and capacity (Table I.1).[1] As of March 31, 2001, 17 states operated Medicaid expansion programs (referred to as M-SCHIP programs), 16 states operated separate child health programs (referred to as S-SCHIP programs), and 18 states used both approaches to expand coverage (referred to as combination programs).

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[1] In addition, the five territories utilize title XXI funds to cover costs associated with their Medicaid populations after they exhaust their Medicaid funds. (Medicaid funds are capped for the territories.) The territories' programs are profiled in Appendix A of this report.

TABLE I.1

PROGRAMS FUNDED THROUGH TITLE XXI, AS OF MARCH 31, 2001

State	Type of SCHIP Program	Program Name[a]	Date Enrollment Began	
			M-SCHIP	S-SCHIP
Alabama[b]	COMBO	Medicaid Expansion/ALL Kids	February 1998	October 1998
Alaska	M-SCHIP	Denali KidCare	March 1999	-
Arizona	S-SCHIP	KidsCare	-	November 1998
Arkansas[b,c]	M-SCHIP	Arkansas Medicaid Program	October 1998	-
California[b]	COMBO	Medi-Cal for Children/Healthy Families Program	March 1998	July 1998
Colorado	S-SCHIP	Child Health Plan Plus (CHP+)	-	April 1998
Connecticut	COMBO	Husky	October 1997	July 1998
Delaware	S-SCHIP	Delaware Healthy Children Program	-	February 1999
District of Columbia	M-SCHIP	DC Healthy Families	October 1998	-
Florida[b,d]	COMBO	Medicaid for Teens/Healthy Kids	April 1998	April 1998
Georgia	S-SCHIP	PeachCare for Kids	-	November 1998
Hawaii	M-SCHIP	Hawaii Title XXI Program	July 2000	-
Idaho	M-SCHIP	Idaho Children's Health Insurance Program	October 1997	-
Illinois	COMBO	KidCare Assist Expansion/KidCare Share/KidCare Premium	January 1998	October 1998
Indiana	COMBO	Hoosier Healthwise	June 1997	January 2000
Iowa	COMBO	Medicaid/HAWK-I	July 1998	January 1999
Kansas	S-SCHIP	HealthWave	-	January 1999
Kentucky	COMBO	KCHIP	July 1998	November 1999
Louisiana	M-SCHIP	LaCHIP	November 1998	-
Maine	COMBO	Medicaid Expansion/Cub Care	July 1998	August 1998
Maryland[e]	M-SCHIP	Maryland's Children's Health Program	July 1998	-
Massachusetts[f]	COMBO	MassHealth/Family Assistance	October 1997	August 1998
Michigan	COMBO	Healthy Kids/MIChild	April 1998	May 1998
Minnesota	M-SCHIP	Minnesota Medical Assistance Program	September 1998	-
Mississippi[b]	COMBO	Mississippi Health Benefits Program	July 1998	January 2000
Missouri	M-SCHIP	MC+ for Kids	July 1998	-
Montana	S-SCHIP	Children's Health Insurance Plan	-	January 1999
Nebraska	M-SCHIP	Kids Connection	July 1998	-
Nevada	S-SCHIP	Nevada Check-Up	-	October 1998
New Hampshire	COMBO	Healthy Kids	May 1998	January 1999
New Jersey	COMBO	NJ KidCare	February 1998	March 1998
New Mexico	M-SCHIP	State Children's Health Insurance Program	March 1999	-
New York[b]	COMBO	Medicaid/Child Health Plus (CHPlus)	January 1999	April 1998
North Carolina	S-SCHIP	NC Health Choice for Children	-	October 1998
North Dakota[b]	COMBO	Healthy Steps	October 1998	November 1999
Ohio	M-SCHIP	Healthy Start	January 1998	-
Oklahoma	M-SCHIP	SoonerCare	December 1997	-
Oregon	S-SCHIP	CHIP	-	July 1998
Pennsylvania	S-SCHIP	CHIP	-	May 1998
Rhode Island	M-SCHIP	RIte Care	October 1997	-
South Carolina	M-SCHIP	Partners for Healthy Children	October 1997	-
South Dakota	COMBO	South Dakota's Health Insurance Program/CHIP-NM	July 1998	July 2000
Tennessee	M-SCHIP	TennCare for Children	October 1997	-
Texas[b]	COMBO	Medicaid	July 1998	April 2000
Utah	S-SCHIP	Utah CHIP	-	August 1998

TABLE I.1 *(continued)*

State	Type of SCHIP Program	Program Name[a]	Date Enrollment Began M-SCHIP	 S-SCHIP
Vermont	S-SCHIP	Dr. Dynasaur	-	October 1998
Virginia	S-SCHIP	Family Access to Medical Insurance Security Plan (FAMIS)	-	October 1998
Washington	S-SCHIP	Washington State CHIP	-	February 2000
West Virginia	S-SCHIP[g]	WV SCHIP	July 1998	April 1999
Wisconsin	M-SCHIP	BadgerCare	April 1999	-
Wyoming	S-SCHIP	Wyoming Kid Care	-	December 1999

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations, Section 2.1 of State Evaluation Framework, and updates provided by HCFA.

NOTE: The type of SCHIP program is as of March 31, 2001.

[a] When more than one name is noted, the first is that of the M-SCHIP program; and the rest are the names of S-SCHIP programs.

[b] In these states, the M-SCHIP component was designed to accelerate Medicaid coverage of children born before September 30, 1983. As of October 1, 2002, the M-SCHIP component will no longer exist, and the programs will become S-SCHIP only.

[c] Arkansas received approval to establish an S-SCHIP component that will cover children up to 200 percent of poverty. However, to implement the S-SCHIP component, the state must eliminate its M-SCHIP component, which requires an amendment to its Medicaid section 1115 demonstration waiver. This amendment is currently under consideration by CMS.

[d] Florida also uses title XXI funds for its MediKids, CMS (Children's Medical Services), and BHSCN (Behavioral Network) programs. These programs cover children under age five, those with special health care needs, and those with serious behavioral health care needs, respectively. Enrollment for these programs began on October 1, 1998.

[e] Maryland became a combination SCHIP program when it implemented a separate state program (S-SCHIP) on July 1, 2001.

[f] Massachusetts also uses title XXI funds for its CommonHealth program. This program covers disabled children. Enrollment began on October 1, 1997.

[g] As of October 13, 2000, West Virginia's SCHIP program was amended to incorporate the M-SCHIP component into the S-SCHIP component, effectively eliminating the M-SCHIP program.

M-SCHIP = State operates Medicaid expansion program

S-SCHIP = State operates separate child health program

COMBO = State operates both an M-SCHIP and S-SCHIP program

Most states that chose the Medicaid expansion approach reported that they did so because building on the existing Medicaid infrastructure would be more cost effective in their state than developing a new administrative structure separate from Medicaid. These states reported that they preferred to take advantage of Medicaid's existing outreach and enrollment systems, benefit structure, provider networks, purchasing arrangements, claims processing, and data systems. These states noted that they could implement a Medicaid expansion more quickly than a separate child health program; provide better continuity of care for children who move between traditional Medicaid and M-SCHIP; and avoid confusion among providers and families that might arise due to multiple programs. Moreover, states receive title XXI enhanced Federal matching funds for appropriate costs incurred by their M-SCHIP programs.[2]

States that opted for a separate child health program indicated they wanted to take advantage of the flexibility under title XXI to design their program according to the needs in the state. A number of these states attempted to simulate the private health insurance market in their S-SCHIP program, in terms of marketing approach, benefit package, cost-sharing structure, and provider networks.[3] Some states designed their S-SCHIP programs to resemble private health insurance products, in an effort to reduce crowd-out and to increase public support by separating the program more clearly from Medicaid.[4] Also, states have more flexibility under a separate child health program to control enrollment with enrollment caps or waiting lists. This may also make it easier for states to monitor costs and work within budgets.

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[2] Under title XXI, states that implement an M-SCHIP program can have their SCHIP expenditures that exceed available title XXI funding (including administrative costs) matched at the regular Medicaid rate. States with S-SCHIP programs are not eligible to claim a Federal match for expenditures that exceed available title XXI funding.

[3] The term "private health insurance" is used throughout this report as a generic term referring to both group health plan coverage and individual health insurance.

Some states—such as Florida, New York, and Pennsylvania—built on preexisting programs to develop their separate child health programs.[5] Others—Alabama, Arkansas, Illinois, Indiana, Iowa, Maryland, North Dakota, South Dakota, Texas, and West Virginia—initially implemented a Medicaid expansion component under their state plan, but subsequently amended their plan and added a separate child health program.

Title XXI provided states with the flexibility to implement their SCHIP programs gradually. Title XXI authorized that enrollment could begin as early as October 1, 1997, and eight states began covering children under SCHIP during 1997 (Table I.1). The majority of states (34 in all) began enrollment in 1998, while 7 states began enrollment in 1999. Two states, Hawaii and Washington, began enrolling children in 2000.

State appropriations provide the major source of nonfederal funding for SCHIP, according to the state evaluations. Nineteen states reported that they combined state appropriations with other resources:

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[4] However, some states that created separate child health programs have adapted features of traditional Medicaid programs to promote seamless transitions between programs and to contain administrative costs. Virginia, for example, reported that its S-SCHIP program uses Medicaid income methodologies to determine eligibility, a nearly identical menu of benefits, and the same managed care options.

[5] The title XXI legislation defined "existing comprehensive state-based coverage" as a child health coverage program that covered a range of benefits; was operational at the time the title was enacted; was administered or overseen by the state; received state funds; and specifically, was offered in New York, Florida, or Pennsylvania.

- Fifteen states reported that their SCHIP programs were supported by foundation grants.[6]
- Eight states reported relying on county and local funds (including funds from local school boards).[7]
- Five states used private donations to finance certain aspects of their SCHIP programs. For example, California implemented a private sponsorship program that allows organizations and individuals to sponsor the premiums of new enrollees for their first year of coverage. Missouri indicated that several significant, anonymous donations supported outreach activities in Washington County.[8]

Nine states used title XXI funds to fund innovative types of coverage, including supplemental services for children with special health care needs, premium assistance to buy into employer-sponsored insurance (ESI) coverage, and family coverage.

- Five states (Alabama, Connecticut, Delaware, Florida, and Massachusetts) used title XXI funds to cover supplemental services for children with special health care needs. Connecticut, for example, implemented HUSKY Plus Behavioral and HUSKY Plus Physical to augment the services provided under the state's S-SCHIP program; children must meet specific diagnostic and functional criteria to qualify for enhanced benefits.

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[6] The 15 states that reported using foundation grants were: Alaska, California, Colorado, Delaware, Idaho, Iowa, Kansas, Louisiana, Missouri, Nebraska, New Hampshire, New Jersey, North Carolina, Virginia, and Wyoming. The states were not clear in their evaluations how this funding was used and whether this funding was directly controlled by the state. Additionally, while only 15 states indicated that foundation grants were used, all states have access to funding from the Robert Wood Johnson Foundation's Covering Kids initiative. Some states had direct control of this funding because the grant was issued to the state. Other states coordinated efforts with private organizations that received the funding. Covering Kids is a national initiative to increase the number of children with health insurance coverage. Three-year grants, funded by The Robert Wood Johnson Foundation, support 51 statewide and 171 local coalitions in conducting outreach initiatives and working toward enrollment simplification and coordination of health coverage programs for low-income children. RWJF launched a new initiative in 2001, Covering Kids and Families, to pursue similar goals for children and adults.

[7] The eight states that reported using county or other local funds were: California, Colorado, Florida, Illinois, Iowa, Louisiana, Massachusetts, and South Carolina.

[8] The five states that reported using private donations were: California, Colorado, Iowa, Missouri, and New Jersey.

- Five states (Maryland, Massachusetts, Mississippi, Virginia, and Wisconsin) used title XXI funds to buy into ESI coverage. In addition, Illinois offered an ESI program that used only state funds. These states hope that coordination with ESI will increase coverage and minimize crowd-out.
- Six states (Arizona, California, Minnesota, New Jersey, Rhode Island, and Wisconsin) received approval for SCHIP section 1115 demonstrations, which allowed them to use title XXI funds to cover adults.[9] The states hope that by expanding SCHIP to cover parents and/or pregnant women, they will be able to increase the enrollment of children in SCHIP.

The SCHIP program continues to grow and evolve, with states modifying their approaches and expanding eligibility as they gain experience and knowledge. As of March 7, 2001, 41 states had received approval for 75 program amendments from the Centers for Medicare & Medicaid Services (CMS).[10] Another nine states had amendments pending. (Appendix B lists the amendments approved as of March 7, 2001.) As the statute intended, each state has taken a unique approach to designing and implementing SCHIP, resulting in considerable diversity across states.

B. RATIONALE FOR THIS REPORT

Congress mandated that states evaluate the effectiveness of their SCHIP programs and submit a report to CMS by March 31, 2000. Congress further required that the Secretary of the Department of Health and Human Services (DHHS) submit a report to Congress by December 31, 2001, based on the states' evaluations. Recognizing these statutory requirements—as well as the need for more in-depth assessment of the performance of SCHIP programs—CMS contracted with Mathematica Policy Research, Inc. (MPR) to conduct a national evaluation of SCHIP,[11] and assist with developing the report to Congress.

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[9] Arizona's SCHIP section 1115 demonstration was approved under the Health Insurance Flexibility and Accountability (HIFA) Initiative on December 12, 2001 and allows the state to use title XXI funds to cover approximately 50,000 adults. California's SCHIP section 1115 demonstration was approved under HIFA on January 25, 2002 and allows the state to use title XXI funds to expand coverage to approximately 275,000 uninsured custodial parents, relative caretakers, and legal guardians of children eligible for Medicaid or SCHIP.

[10] The Centers for Medicare & Medicaid Services was formerly the Health Care Financing Administration (HCFA).

To assist states in evaluating their programs, the National Academy for State Health Policy (NASHP) convened a workgroup of state and Federal officials, policymakers, and researchers to develop a standardized framework that states could use to prepare their evaluations. The framework was intended to facilitate cross-state comparison, based on a common structure and format. In addition, the framework was designed to accommodate the diversity of state approaches to providing health insurance coverage afforded by title XXI and to allow states flexibility in highlighting their key accomplishments and progress (NASHP 1999).

It is important to note that this report is based on the state evaluations, which provide a snapshot of the features and activities of SCHIP programs as of March 2000. The state evaluations varied substantially in length and in the level of detail reported on state activities. This report highlights examples of SCHIP program features and performance for as many states as possible. In some cases, however, limited or ambiguous information precluded us from citing certain examples.

Key program changes that have occurred since the state evaluations were submitted have been tracked, and where appropriate, have been included in this report. Given that states have used the flexibility allowed under title XXI to continue to adapt their SCHIP programs to meet the needs in their state, some of the information contained within this report may no longer be accurate.

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[11] The Balanced Budget Refinement Act of 1999 (BBRA) appropriated additional funds for the evaluation of SCHIP. This effort, administered by the Office of the Assistant Secretary for Planning and Evaluation (ASPE), involves an independent study of 10 states, including a survey of the target population. The Secretary is submitting a separate report, as mandated under BBRA.

C. ORGANIZATION OF THIS REPORT

This report describes the early implementation and progress of SCHIP programs in reaching and enrolling eligible children and reducing the number of low-income children who are uninsured.[12] This analysis relies upon the evidence presented by the states in their evaluations. The majority of the evidence presented is descriptive in nature; given the short time frame between implementation and evaluation, states had limited ability to gather quantitative data by the time they submitted their evaluations.[13] Table I.2 lists the elements that title XXI required each state to address in its evaluation, along with the chapter of this report that addresses each element.

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[12] This report builds on an earlier report produced by MPR entitled, "Implementation of the State Children's Health Insurance Program: Momentum is Increasing After a Modest Start," released in January 2001. The report is available electronically on CMS's Web site at www.hcfa.gov/stats/schip1.pdf.

[13] The DHHS Office of the Inspector General (OIG) similarly concluded that state evaluations tend to be descriptive rather than evaluative (DHHS/OIG 2001). The OIG also raised concerns about the lack of objective measurements and problems with the data.

TABLE I.2

CROSSWALK OF TITLE XXI STATUTES TO THIS REPORT

Section of Statute	Statutory Language	Chapter of Report that Addresses Statutory Requirement
2108(b)(1)(A)	An assessment of the effectiveness of the State plan in increasing the number of children with creditable health coverage	IX
2108(b)(1)(B)	A description and analysis of the effectiveness of elements of the State plan, including--	
(i)	the characteristics of the children and families assisted under the State plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the State plan and after eligibility for the State plan ends,	III
(ii)	the quality of health coverage provided including the types of benefits provided,	IV
(iii)	the amount and level (including payment of part or all of any premium) of assistance provided by the State,	IV
(iv)	the service area of the State plan,	III
(v)	the time limits for coverage of a child under the State plan,	III
(vi)	the State's choice of health benefits coverage and other methods used for providing child health assistance, and	V
(vii)	the sources of non-Federal funding used in the State plan.	I
2108(b)(1)(C)	An assessment of the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children.	VI
2108(b)(1)(D)	A review and assessment of State activities to coordinate the plan under this title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.	VI, VIII
2108(b)(1)(E)	An analysis of changes and trends in the State that affect the provision of accessible, affordable, quality health insurance and health care to children.	II
2108(b)(1)(F)	A description of any plans the State has for improving the availability of health insurance and health care for children.	VII
2108(b)(1)(G)	Recommendations for improving the program under this title.	X
2108(b)(1)(H)	Any other matters the State and the Secretary consider appropriate.	

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II. FACTORS AFFECTING THE PROVISION OF HEALTH INSURANCE TO LOW-INCOME CHILDREN

SCHIP was enacted in the midst of a dynamic period in American health care. While the nation was undergoing its largest post-World War II economic expansion, many other forces were transforming the health care delivery system. Despite the economic boom, the number of uninsured rose during the 1990s, due both to declines in the take-up rates for private insurance coverage and to shrinking Medicaid enrollment—created in large part by the delinking of cash assistance and Medicaid coverage under welfare reform. At the same time, increased managed care penetration reshaped the way in which health care was being accessed, delivered, and funded. The changing environment provides an important backdrop for the design and implementation of states' SCHIP programs.

The title XXI statute mandated that state evaluations provide an "analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children" (Section 2108(b)(1)(E)). This chapter describes two factors that may affect the provision of health insurance to low-income children: (1) changes that states made to their non-Medicaid child health programs as a result of SCHIP; and (2) changes in the public and private health care sectors that have taken place since the implementation of SCHIP.

A. THE ROLE OF PREEXISTING STATE PROGRAMS

Low-income children and families historically have received health care coverage and benefits from a patchwork of programs. Medicaid has provided coverage to a large share of low-income families since the mid-1960s, but many states (or other entities) have designed programs to cover families ineligible for Medicaid. These programs typically targeted families whose incomes exceeded Medicaid limits or who were ineligible for Medicaid because of restrictions based on immigration status.[1]

Table II.1 highlights the non-Medicaid child health programs that existed prior to SCHIP, as well as what happened to these programs after SCHIP was implemented. Twenty-seven states reported having one or more child health programs prior to SCHIP. Twenty-two of these states decided to establish S-SCHIP programs (either alone or in combination with M-SCHIP programs). For states with preexisting child health programs, the implementation of SCHIP created three possible scenarios: (1) the consolidation of preexisting state programs in SCHIP, (2) retention of preexisting state programs alongside SCHIP, and (3) consolidation of some programs but retention of others.

In 9 of the 27 states, administrators elected to roll all of their preexisting plans into SCHIP (Connecticut, Georgia, Kansas, Louisiana, Michigan, New Jersey, New York, North Carolina, and West Virginia). Prior to SCHIP, many states reported that lack of funding limited the scope of the programs and the state's ability to provide coverage to uninsured children. Title XXI provided the needed funding for states to expand existing programs and offer comprehensive coverage. In New Jersey, for example, the Health Access program provided heavily subsidized insurance coverage to families and individuals who were uninsured for at least 12 months and covered more than 7,500 children at its peak. A lack of state funding in 1996 caused the state to discontinue enrollment of new eligibles in the program, but coverage of current eligibles

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[1] Blue Cross and Blue Shield Caring Programs were designed to provide subsidized coverage for primary and preventive care services for low-income children who did not qualify for Medicaid. Prior to SCHIP, Caring Programs were in operation in 25 states. The programs varied from state to state, but most covered children under age 19. The programs received the majority of their funding from the private sector, although a few states provided additional funds. Most Caring Programs remained relatively small because of their dependence on charitable contributions (Edmunds and Coye 1998).

TABLE II.1

STATUS OF PREEXISTING STATE CHILD HEALTH PROGRAMS

State	SCHIP Program Type	Preexisting State Child Health Programs
Alabama	COMBO	**Programs Still in Existence** • Alabama Child Caring Foundation (ACCF) provides only ambulatory care (no hospital, dental, or pharmaceutical benefits) to children ages 0 to 18 who are ineligible for Medicaid or SCHIP. ACCF transferred some children to SCHIP, but continues to maintain an enrollment of about 6,000 children per year.
Arizona	S-SCHIP	**Programs Folded into SCHIP** • Eligible Assistance Children (EAC) covered children under age 14 who were recipients of Food Stamps, and ineligible for Medicaid. • Medically Indigent/Medically Needy (MI/MN) covered individuals with income at or below $3,200 per year, or those with sufficient medical bills to "spend down" to $3,200 per year (Arizona's spend-down criteria was not the same as Federal medically needy criteria). • Eligible Low Income Children (ELIC) covered children under age 14 whose families had income exceeding MI/MN standards, but below 100% FPL. **Programs Still in Existence** • Premium Sharing Program (PSP) provides comprehensive health care benefits to individuals up to 200% FPL (400% FPL for those with chronic conditions). PSP is funded with tobacco tax funds and member premiums. • State Emergency Services (SES) covers children who are ineligible for SCHIP because of citizenship requirements, but are able to meet income and resource criteria for MI/MN or ELIC. SES provides only emergency services on a fee-for-service basis.
California	COMBO	**Programs Still in Existence** • Access for Infants and Mothers (AIM) targets pregnant women and newborns ages 0 to 2 with income from 200 to 300% FPL. • Rural Health Services (RHS) funds uncompensated care for individuals in small rural counties. • Expanded Access to Primary Care (EAPC) targets individuals below 200% FPL, and provides funds to primary care clinics in underserved areas and for underserved populations. • Seasonal Agricultural and Migratory Workers Health Program provides funds to primary care clinics that serve migratory workers and families.
Colorado	S-SCHIP	**Programs Folded into SCHIP** • The Colorado Child Health Plan (CCHP) covered children ages 0 to 12 for outpatient services, mostly in rural areas. **Programs Still in Existence** • The Colorado Indigent Care Plan (CICP) partially reimburses providers for care delivered to uninsured Coloradoans.
Connecticut	COMBO	**Programs Folded into SCHIP** • Healthy Steps provided a limited health insurance package to children in New Haven County with household incomes up to 200% FPL.

TABLE II.1 *(continued)*

State	SCHIP Program Type	Preexisting State Child Health Programs
Delaware	S-SCHIP	**Programs Still in Existence** • The Nemours Foundation covered children not eligible for Medicaid up to 175% FPL. With the implementation of SCHIP, Nemours adjusted its eligibility criteria to provide coverage to children ineligible for SCHIP or Medicaid.
District of Columbia	M-SCHIP	**Programs Folded into SCHIP** • KidsCare was a privately funded program that provided insurance to uninsured children. The program stopped operating once SCHIP began. **Programs Still in Existence** • KaiserKids is a privately funded program that covers uninsured children. Prior to SCHIP, the program covered uninsured children up to 200% FPL. Once Healthy Families began, KaiserKids adjusted its eligibility criteria. The program now covers children up to 250% FPL who are ineligible for SCHIP or Medicaid.
Florida	COMBO	**Programs Still in Existence** • Healthy Kids targets uninsured school-age children ineligible for Medicaid or the CMS Network. While some children were transferred to SCHIP, the program continues to serve those who are ineligible for SCHIP (non-citizen children, 19-year-olds, and uninsured children with income above SCHIP eligibility limits).
Georgia	S-SCHIP	**Programs Folded into SCHIP** • The Caring Program for Children provided primary and preventive health care coverage to uninsured children who were ineligible for Medicaid and not enrolled in any private health plan. The benefit package included preventive care, emergency medical care, and prescription drugs. The program was discontinued in April 1999 with the implementation of PeachCare.
Kansas	S-SCHIP	**Programs Folded into SCHIP** • The Caring Program for Children served children in families with too much income to qualify for Medicaid, but not enough income to afford private coverage. The program was discontinued with the implementation of HealthWave.
Louisiana	M-SCHIP	**Programs Folded into SCHIP** • The Caring Program provided primary, preventive, and emergency health care to uninsured children not eligible for Medicaid.
Maryland	M-SCHIP	**Programs Still in Existence** • Carroll County's Children's Fund Health and Wellness Care Program provides primary and preventive health care for children ages 0 to 18 who do not qualify for Medicaid or SCHIP. The program provides primary and preventive care, limited pharmacy benefits, and basic diagnostic and laboratory services. • Montgomery County's Care for Kids Program provides health care for undocumented children. • The Prince George's County Medical Care for Children Partnership serves children ages 0 to 18 with income from 200 to 250% FPL, as well as undocumented children. The program is administered by Catholic Charities. **Programs Folded into SCHIP** • The Anne Arundel County Caring Program for Children covered uninsured children ages 16 to19. It offered access to preventive and primary care, prescriptions, eye exams and glasses, and selected outpatient surgeries. • Allegany Health Right provided limited medical care to low-income individuals unable to afford health care. Services included physician care, prescriptions, diagnostic services, hospital sliding scale payments, and advocacy services.

TABLE II.1 *(continued)*

State	SCHIP Program Type	Preexisting State Child Health Programs
Massachusetts	COMBO	**Programs Still in Existence** • The Children's Medical Security Plan (CMSP) provides limited preventive and primary care for children ages 0 to 18. Some children were transferred to SCHIP, but CMSP continues to cover children who are ineligible for SCHIP (those in families with incomes above 200% FPL or undocumented aliens). • The CommonHealth covers uninsured disabled adults and children with family incomes above 200% FPL, based on a sliding fee scale.
Michigan	COMBO	**Programs Folded into SCHIP** • The Caring Program for Children covered individuals ineligible for Medicaid.
Minnesota	M-SCHIP	**Programs Still in Existence** • The General Assistance Medical Care Program (GAMC) covers children who do not meet the citizenship requirements of Medicaid.
Nevada	S-SCHIP	**Programs Folded into SCHIP** • The State Health Division had a dental program for children who were ineligible for Medicaid and had income under 200% FPL. **Programs Still in Existence** • Children's Special Health Care Services (CSHCS) covered children ages 0 to 21 who were under 200% FPL. Uninsured children ages 0 to 18 who were at or below 200% FPL were referred to SCHIP. CSHCS continues to cover children ages 19 to 21 with income under 200% FPL.
New Hampshire	COMBO	**Programs Still in Existence** • New Hampshire Healthy Kids Corporation provides insurance to families with income between 300 and 400% FPL. Families pay a premium of $80 per child per month.
New Jersey	COMBO	**Programs Folded into SCHIP** • New Jersey Health Access provided heavily subsidized insurance to families and individuals who had been uninsured for a minimum of 12 months and had income at or below 250% FPL.
New York	COMBO	**Programs Folded into SCHIP** • Child Health Plus provided subsidized health insurance to low-income children.
North Carolina	S-SCHIP	**Programs Folded into SCHIP** • The Caring Program for Children used private donations and very limited state appropriations to cover low-income children.
North Dakota	COMBO	**Programs Still in Existence** • The Caring Program, operated by Noridian Mutual Insurance, provides limited health insurance to low-income children.
Oregon	S-SCHIP	**Programs Still in Existence** • Family Health Insurance Assistance Program (FHIAP) is a public-private partnership that provides subsidized health insurance benefits for uninsured Oregonians up to 170% FPL, who are uninsured for six months. FHIAP emphasizes care for uninsured children.
Pennsylvania	S-SCHIP	**Programs Still in Existence** • Pennsylvania's Children's Health Insurance Program provides subsidized health care for uninsured children who are ineligible for Medicaid, up to 235% FPL. Children up to 200% FPL were transferred to SCHIP.

TABLE II.1 *(continued)*

State	SCHIP Program Type	Preexisting State Child Health Programs
Texas	COMBO	**Programs Still in Existence** • Texas Healthy Kids Corporation (THKC) used donations to provide subsidized premiums for children up to 185% FPL. The program continues to offer full-pay coverage for children who are ineligible for SCHIP.
Washington	S-SCHIP	**Programs Still in Existence** • Basic Health Plan (BHP) covers individuals and families up to 200% FPL. BHP has subsidized and unsubsidized packages.
West Virginia	S-SCHIP	**Programs Folded into SCHIP** • The Caring Program for Children covered children in families with income up to 150% FPL for primary care and outpatient diagnostic and treatment services.
Wisconsin	M-SCHIP	**Programs Still in Existence** • WisconCare provides a limited scope of outpatient primary care and inpatient maternity/delivery services in 17 counties with high unemployment. • General Relief Medical Care is provided in some counties at their discretion. • Health Insurance Risk Sharing Program (HIRSP) provides health insurance to persons that cannot get private health insurance or are not eligible for Medicaid or BadgerCare.

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations, Section 2.2 of the State Evaluation Framework.

NOTE: Alaska, Arkansas, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Maine, Mississippi, Missouri, Montana, Nebraska, New Mexico, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, and Wyoming did not report any preexisting (non-Medicaid) child health programs.

continued. Children who remained enrolled in early 1998 were transferred to New Jersey's SCHIP program.

Thirteen states reported that they retained their preexisting plans alongside SCHIP (Alabama, California, Delaware, Florida, Massachusetts, Minnesota, New Hampshire, North Dakota, Oregon, Pennsylvania, Texas, Washington, and Wisconsin). These states reported that eligible children were transferred to SCHIP, while the remaining programs served children who were ineligible for Medicaid or SCHIP—for example, children in families with incomes at thresholds above the SCHIP maximum or families ineligible for SCHIP and Medicaid because they did not meet the citizenship requirements. As an example, many children enrolled in the Alabama Child Caring Foundation (ACCF) program were transferred to ALL Kids, the state's S-SCHIP program. ACCF subsequently adjusted its eligibility criteria to cover children ineligible for the S-SCHIP program. The program was established by Blue Cross/Blue Shield of Alabama in the mid-1980s and served uninsured children from birth to age 18 who were ineligible for Medicaid. The program covered only ambulatory care (no hospital, dental, or pharmacy services were covered). Alabama used many of the lessons learned from ACCF in the design of ALL Kids, including simplifying the application process and providing continuous eligibility. ACCF continues to cover about 6,000 children each year.

Finally, five states that operated multiple child health programs prior to SCHIP indicated that they chose to roll some components into SCHIP, and keep other components operating independently (Arizona, Colorado, District of Columbia, Maryland, and Nevada). Prior to SCHIP, Arizona had an extensive network of programs for uninsured children who did not qualify for Medicaid. The state rolled three programs into SCHIP—the Medically Indigent/Medically Needy (MI/MN), Eligible Assistance Children (EAC), and Eligible Low-Income Children (ELIC)—all of which covered low-income uninsured children who were not eligible for Medicaid. The state continued to operate two programs independently. The Premium Sharing Program offered premium assistance to children in families with gross income up to 200 percent of poverty (and up to 400 percent of poverty for children with chronic illnesses). The Emergency Services Program covered children who met income standards for S-SCHIP eligibility but who did not meet the citizenship requirements.

In summary, the advent of title XXI allowed 27 states to build on an existing infrastructure of health programs for low-income children. According to the state evaluations, one-third of these states discontinued their preexisting programs and transferred enrollees to SCHIP, while two-thirds maintained some or all of their preexisting programs to continue to serve children who were ineligible for Medicaid or SCHIP.

B. OTHER CHANGES AND TRENDS AFFECTING THE PROVISION OF HEALTH INSURANCE TO LOW-INCOME CHILDREN

Many other "changes and trends" have occurred since SCHIP was implemented, which may—directly or indirectly—affect the availability or affordability of health insurance or health care for children. The state evaluations described changes in the public and private sectors that have occurred since the implementation of SCHIP.[2] Table II.2 presents a summary of state responses.[3]

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[2] Hawaii did not report because their program was not implemented until July 2000. Tennessee did not complete this section of the template.

[3] It should be noted that Table II.2 may not represent a comprehensive list of changes taking place in all states; rather, it reflects those changes and trends that states reported as affecting the provision of health insurance and health care for children.

TABLE II.2

CHANGES AND TRENDS IN THE STATES SINCE THE IMPLEMENTATION OF SCHIP

State	Program Type	Changes to the Medicaid Program						Impact of Welfare Reform	Development of New Health Care Programs or Services For Targeted Low-Income Children
		Easing of Documentation Requirements	Elimination of Face-to-Face Eligibility Interviews	Provision of Continuous Coverage	Elimination of Assets Tests	Presumptive Eligibility	Coverage of SSI Children		
Total		31	30	18	15	5	1	33	5
Alabama	COMBO			✓				✓	
Alaska	M-SCHIP	✓	✓	✓				✓	
Arizona	S-SCHIP	✓	✓					✓	
Arkansas	M-SCHIP							✓	
California	COMBO	✓	✓	✓	✓			✓	
Colorado	S-SCHIP	✓	✓					✓	
Connecticut	COMBO	✓		✓				✓	
Delaware	S-SCHIP	✓		✓				✓	
District of Columbia	M-SCHIP	✓	✓		✓			✓	
Florida	COMBO	✓	✓	✓				✓	
Georgia	S-SCHIP	✓	✓				✓	✓	
Hawaii	M-SCHIP								
Idaho	M-SCHIP	✓	✓	✓				✓	✓
Illinois	COMBO	✓	✓	✓	✓			✓	
Indiana	COMBO	✓	✓	✓				✓	
Iowa	COMBO		✓		✓			✓	
Kansas	S-SCHIP	✓	✓	✓	✓			✓	
Kentucky	COMBO	✓	✓						
Louisiana	M-SCHIP	✓	✓	✓	✓			✓	
Maine	COMBO			✓					
Maryland	M-SCHIP	✓	✓		✓			✓	
Massachusetts	COMBO	✓			✓	✓		✓	
Michigan	COMBO	✓							
Minnesota	M-SCHIP	✓	✓					✓	
Mississippi	COMBO	✓	✓	✓	✓			✓	
Missouri	M-SCHIP	✓	✓					✓	
Montana	S-SCHIP								
Nebraska	M-SCHIP	✓	✓	✓		✓			
Nevada	S-SCHIP	✓	✓					✓	
New Hampshire	COMBO	✓	✓						
New Jersey	COMBO	✓	✓			✓		✓	✓
New Mexico	M-SCHIP		✓	✓	✓	✓		✓	
New York	COMBO					✓			
North Carolina	S-SCHIP		✓	✓				✓	
North Dakota	COMBO								
Ohio	M-SCHIP		✓					✓	
Oklahoma	M-SCHIP	✓	✓		✓				
Oregon	S-SCHIP								✓
Pennsylvania	S-SCHIP	✓						✓	
Rhode Island	M-SCHIP	✓	✓	✓	✓			✓	
South Carolina	M-SCHIP	✓	✓	✓	✓			✓	
South Dakota	COMBO	✓	✓		✓			✓	
Tennessee	M-SCHIP								
Texas	COMBO								
Utah	S-SCHIP	✓							
Vermont	S-SCHIP								
Virginia	S-SCHIP		✓					✓	✓
Washington	S-SCHIP								
West Virginia	S-SCHIP								
Wisconsin	M-SCHIP							✓	
Wyoming	S-SCHIP				✓				✓

TABLE II.2 *(continued)*

		Changes in the Private Insurance Market that Could Affect Affordability or Accessibility to Private Health Insurance					Changes in the Delivery System		Changes in Demographic or Socioeconomic Context	
State	Program Type	Health Insurance Premium Rate Increases	Changes in Insurance Carrier Participation	Changes in Employee Cost Sharing	Legal or Regulatory Changes Related to Insurance	Availability of Subsidies for Adult Coverage	Changes in Extent of Managed Care Penetration	Changes In Hospital Marketplace	Changes in Economic Circumstances	Changes in Population Characteristics
Total		34	15	14	14	3	21	10	24	17
Alabama	COMBO				✓		✓	✓		
Alaska	M-SCHIP	✓		✓						
Arizona	S-SCHIP								✓	✓
Arkansas	M-SCHIP	✓		✓						
California	COMBO	✓		✓					✓	✓
Colorado	S-SCHIP	✓					✓	✓		
Connecticut	COMBO	✓	✓				✓		✓	
Delaware	S-SCHIP	✓		✓					✓	✓
District of Columbia	M-SCHIP								✓	
Florida	COMBO	✓								✓
Georgia	S-SCHIP	✓			✓			✓	✓	✓
Hawaii	M-SCHIP									
Idaho	M-SCHIP	✓	✓	✓	✓		✓		✓	✓
Illinois	COMBO	✓			✓		✓			
Indiana	COMBO								✓	✓
Iowa	COMBO						✓	✓	✓	✓
Kansas	S-SCHIP	✓	✓		✓				✓	
Kentucky	COMBO	✓	✓	✓	✓		✓			
Louisiana	M-SCHIP	✓					✓		✓	
Maine	COMBO	✓	✓				✓			
Maryland	M-SCHIP								✓	
Massachusetts	COMBO	✓	✓			✓	✓			
Michigan	COMBO	✓		✓			✓			
Minnesota	M-SCHIP	✓		✓					✓	✓
Mississippi	COMBO						✓			
Missouri	M-SCHIP	✓	✓		✓					✓
Montana	S-SCHIP	✓					✓		✓	✓
Nebraska	M-SCHIP	✓	✓		✓		✓	✓	✓	
Nevada	S-SCHIP	✓			✓		✓		✓	✓
New Hampshire	COMBO	✓	✓						✓	
New Jersey	COMBO	✓	✓				✓	✓		
New Mexico	M-SCHIP									
New York	COMBO		✓			✓				
North Carolina	S-SCHIP								✓	✓
North Dakota	COMBO	✓		✓					✓	✓
Ohio	M-SCHIP		✓		✓				✓	
Oklahoma	M-SCHIP	✓								
Oregon	S-SCHIP	✓				✓	✓			
Pennsylvania	S-SCHIP	✓	✓		✓		✓	✓		
Rhode Island	M-SCHIP	✓	✓	✓	✓		✓	✓	✓	
South Carolina	M-SCHIP	✓	✓	✓	✓			✓	✓	✓
South Dakota	COMBO									
Tennessee	M-SCHIP									
Texas	COMBO	✓								✓
Utah	S-SCHIP									
Vermont	S-SCHIP	✓								
Virginia	S-SCHIP	✓		✓			✓	✓	✓	✓
Washington	S-SCHIP									
West Virginia	S-SCHIP	✓		✓			✓			
Wisconsin	M-SCHIP	✓		✓	✓				✓	
Wyoming	S-SCHIP									

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations, Section 2.2.3 of the State Evaluation Framework.

NOTE: The type of SCHIP program is as of March 31, 2001. Tennessee did not complete this section of the state evaluation. Hawaii did not report because their SCHIP program was not implemented until July 2000. Washington did not report any changes or trends because their SCHIP program began only a short time before they submitted their state evaluation.

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1. Changes in the Public Sector

a. Changes to Medicaid

Thirty-nine states and the District of Columbia reported that they made changes to their Medicaid programs following the implementation of SCHIP.[4] States indicated that the changes were made in an attempt to increase the number of children eligible for—and enrolled in—Medicaid by reducing the barriers to enrollment and retention of coverage.

The most common changes to Medicaid centered on streamlining the eligibility determination process and minimizing barriers to enrolling in Medicaid. Thirty-one states reported easing documentation requirements. Massachusetts, for example, reduced the number of pay stubs it requires from families, while Florida allowed families to self-declare their income, without any documentation. The Florida Department of Children and Families used the FLORIDA computer system to verify income information electronically, by searching other computerized databases in the state.

Thirty states reported the elimination of face-to-face interviews for Medicaid. In most states, families now can submit applications via mail, and in Missouri they can submit by fax. In Wisconsin, interviews can now take place over the phone, just as the state does with its Food Stamp Program.

Fifteen states reported that they eliminated asset tests for Medicaid applicants. Massachusetts reported that asset verification was a time-consuming task that was rarely fruitful. In an attempt to streamline the eligibility determination process for SCHIP and Medicaid, California decided to disregard the assets of children ages 1 to 19 in its Federal poverty groups, thereby expanding coverage for children whose families met income standards but who did not meet its resource requirements. California reported that this change also facilitated the development of a joint application for Medicaid and SCHIP.

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[4] This section focuses on changes made by states *since* the implementation of SCHIP. Some states may have made similar changes prior to implementing SCHIP.

States also implemented changes in Medicaid to improve the continuity of coverage. Eighteen states reported that they began providing continuous coverage for Medicaid, allowing children to remain enrolled for longer periods of time without redetermining their eligibility.

b. Impact of Welfare Reform

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 produced significant changes to the U.S. welfare system, as record numbers of families left the welfare rolls and returned to work. With the delinking of Medicaid and cash assistance, families often were not aware that they were eligible to retain Medicaid coverage even if their cash benefits ended, and state administrative systems often were not designed to continue coverage of medical benefits when cash assistance ended. According to the state evaluations, 33 states reported that welfare reform affected health coverage of children, primarily resulting in reductions in Medicaid caseloads. Since the implementation of SCHIP, however, many of the earlier declines in Medicaid enrollment have been curtailed as a result of enhanced outreach under SCHIP, as well as targeted initiatives to reinstate coverage among Medicaid-eligible children whose coverage was inappropriately terminated.

Alaska, for example, reported that they were conducting a study of former welfare recipients, and their eligibility for Medicaid or SCHIP. The state suspected that many of these individuals were employed in service and retail sales jobs, and that their income would qualify them for Medicaid or SCHIP. The state reported that, despite the fact that there was a dramatic decline in the number of families receiving cash assistance, the number of Medicaid recipients increased sharply in fiscal year 1999, the year the state's M-SCHIP program was implemented.

New Jersey reported a similar experience. While the number of children receiving cash assistance fell 41 percent since 1997, the number of children covered by the state's Division of Medical Assistance was largely unchanged. South Dakota reported that it revised its computer system to separate TANF and Medicaid eligibility to assure that Medicaid coverage was not dropped when cash benefits ended.

c. Development of New Health Care Programs or Services for Low-Income Children

Since the implementation of SCHIP, five states reported that they have developed new programs (or expanded existing ones) to improve the availability, affordability, and quality of health care for children.[5] The initiatives reported by these four states were as follows:

- Idaho undertook a statewide immunization initiative to raise immunization rates to 90 percent. The state established a centralized registry for tracking immunizations, appointed an administrator, and collected private funding to support outreach and media campaigns.
- Oregon implemented the Family Health Insurance Assistance Program (FHIAP), a public-private partnership that subsidized health insurance benefits for working people and their dependents.
- Virginia reported that the Virginia Health Care Foundation targeted a wide variety of local programs to uninsured and medically underserved children. The foundation is a private, not-for-profit entity that "leverages public dollars with private sector resources in order to increase access to primary health care." In 1999, the foundation sponsored such initiatives as school-based dental health services, case management for at-risk families, and mental health services.
- Wyoming's Caring Program for Children raised its eligibility level from 150 to 165 percent of poverty.

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[5] This section was intended to include changes made *since* the implementation of SCHIP and, therefore, does not count the initial implementation of SCHIP.

2. Changes in the Private Sector

In addition to a changing landscape in the public provision of health care since the advent of SCHIP, the private market has experienced numerous developments. Increased managed care penetration has changed the manner in which many Americans access and pay for health care, as well as how care is provided. The private insurance market also has experienced increasing cost pressures, as evidenced by the recent growth in health insurance premiums. Thirty-seven states reported that changes in the private market have affected the affordability of or accessibility to private insurance. States also noted that, as costs rise, and access to the private market insurance is constrained, more low-income families may rely on SCHIP or Medicaid for health coverage in the future.

As shown in Table II.2, 34 states reported that health insurance premium rates have been rising since the implementation of SCHIP. In Idaho, premiums jumped significantly in individual and small-group policies. One of the major health insurance companies in the state saw its claims expenses grow from 87 percent of premium dollars in 1994 to 96 percent in 1998. The state feared that this would make private insurance coverage less affordable for low-income families. Nevada's health insurance premium rates increased an average of 10 percent in 1999.

Although 34 states raised concerns about rising premiums, only 14 expressed concern about whether these costs would be passed from employers to employees. Texas noted that the nation's booming economy and tight labor market have prevented firms from passing higher costs along to their employees. They expressed concern, however, that as the economy slows down, this may change. Virginia experienced premium increases of 7.8 percent in 1999 and expected to see increases between 8 and 10 percent in 2000. Virginia said that companies reported a willingness to cover most of the costs due to the strong economy, but the state feared that employers would cut back on the scope of benefits or amount they are willing to contribute if premiums continued to rise. The state expressed concern that this could result in declines in the number of individuals in Virginia who receive and participate in employment-based health insurance.

Fifteen states reported changes in the number of insurance carriers, predominantly in their individual and small-group markets. South Carolina reported significant withdrawals of carriers from the state in 1999, particularly among companies offering small-group coverage. Since New Jersey's KidCare program began, the number of carriers dropped from 28 to 18 in the individual market, and from 55 to 32 in the small business employer market (although many of the exiting plans had only a few contracts in force). The number of HMOs available for SCHIP enrollees also fell from 10 to 6. The state indicated that some of the change was attributable to mergers and acquisitions, while other firms simply withdrew from the health insurance business nationally. Pennsylvania reported that its group and individual health insurance market has remained fairly stable over the past several years. While some carriers did, in fact, exit the market, many had small market shares, and none adversely affected the marketplace.

Fourteen states reported legal or regulatory changes related to insurance since the implementation of SCHIP. The changes were of two basic types: (1) individual or small group market reforms that were designed to make insurance more accessible; and (2) mandates that were imposed on managed care organizations or private insurers. Nebraska, for example, enacted the Small Employer Health Insurance Availability Act, which allowed at least 25 individuals to voluntarily form a group for the sole purpose of purchasing insurance (although the group must meet certain legal requirements before soliciting a bid from a health insurance company or health care provider). Illinois adopted the Managed Care Reform and Patient Rights Act, which became effective January 1, 2000. The legislation intended to increase access to care by expanding the availability of specialty care, emergency care, and transitional care. The legislation also revised grievance/appeals procedures in managed care settings. Nevada's legislature mandated mental health parity, minimum inpatient stays after delivery, and other benefits, while Ohio's legislature passed several bills regulating access to care and requiring internal and external review of health coverage decisions made by insurance corporations.

3. Changes in Delivery Systems

Twenty-one states reported changes in the extent of managed care penetration since SCHIP was implemented. In Alabama, HMOs have been slow to take hold; thus, ALL Kids administrators opted to use the state's existing Preferred Provider Organization (PPO) networks. Colorado chose to use HMOs for its SCHIP program, but expressed concern that market volatility and recent financial pressures may reduce the number of HMOs willing to offer CHP+ coverage, as well as limit the network of providers for those HMOs that do continue to offer coverage.

Ten states reported changes in the hospital marketplace. Nebraska, for example, reported that the Balanced Budget Act of 1997 greatly affected the financial stability of rural hospitals. In 1999, 3 of the state's 64 rural hospitals closed. The state is seeking to have many of its rural hospitals classified as critical access hospitals (CAHs), in order to stabilize and sustain its rural health care delivery systems.

4. Changes in Socioeconomic Characteristics

Economic and demographic changes can influence a state's ability to reduce the number of uninsured individuals. Twenty-four states reported changes in economic circumstances during the period their SCHIP programs were being implemented. In many states, the economy had improved, but this did not necessarily lead to a reduction in the number of uninsured. California reported that unemployment fell to 4.9 percent in 1999 and that 335,000 new jobs were created in the 15 months following SCHIP's inception. The state indicated that many of the newly employed families, however, were employed in jobs that did not offer health insurance coverage; therefore, Medicaid and SCHIP may fill the gaps in providing health care coverage for the children. In Idaho, the statewide unemployment rate dropped to 4.4 percent in 1999; however, closer analysis revealed that the benefits were largely seen in such urban areas as Boise. Rural areas of the state that depend on forestry and mining faced much higher unemployment rates—in the range of 10 to 12 percent.

Seventeen states reported changes in population characteristics, particularly increases in minority populations. For example, Georgia reported that, since 1990, the state's population increased by 17.5 percent overall, while the Hispanic and Asian populations increased by 100 percent and 92 percent, respectively. Such changing population demographics may necessitate that states use a multi-faceted approach to enrollment, such as offering applications and assistance in a variety of languages. For example, Georgia attempted to address the needs of the Hispanic and Asian populations by better targeting of community-based outreach efforts. California used a hotline with as many as 11 language options.

C. CONCLUSION

In addition to expanding coverage beyond Medicaid limits, 27 states used SCHIP as a means to consolidate and enhance the existing infrastructure of health programs for low-income children. Nine of these states discontinued their preexisting child health programs and transferred enrollees to SCHIP. The remaining 18 states transferred eligible children to SCHIP and continued to serve children who were ineligible for Medicaid or SCHIP through preexisting programs. The vast majority of states with preexisting programs—22 of the 27 states—decided to implement S-SCHIP programs, either alone or in combination with M-SCHIP programs.

Since the implementation of SCHIP, states reported many changes that may affect the availability, affordability, and quality of children's health coverage. Thirty-nine states and the District of Columbia reported instituting changes to their Medicaid programs, such as streamlining the eligibility determination process and minimizing barriers to enrollment, while 33 states cited welfare reform as an important change. Thirty-seven states indicated that one or more changes had taken place in the private insurance market, most often citing health insurance premium rate increases (34 states). Changes in the delivery system were less common, including changes in the extent of managed care penetration (21 states) or changes in the hospital marketplace (10 states). States also cited changes in economic circumstances (24 states) or population characteristics (17 states) as factors that could affect the availability or affordability of coverage.

It is important to recognize that these changes may have complex interactions with the availability and source of health insurance coverage for low-income children; however, their precise effects are difficult to quantify and isolate. Some changes—such as efforts to streamline the Medicaid eligibility determination process—were designed to improve enrollment and retention, and to facilitate administration of the program. Other changes—such as increases in insurance premiums—may weaken the infrastructure of the private health insurance market and result in shifts from private to public coverage or increases in the number of children who are uninsured. Finally, changes reported by states in regard to the population demographics and the socioeconomic circumstances of low-income families highlight the challenges that states face in designing and marketing SCHIP programs, and then enrolling and retaining uninsured children in SCHIP.

III. SCHIP ELIGIBILITY CRITERIA AND COVERAGE POLICIES

Title XXI offered states considerable flexibility to establish their SCHIP eligibility criteria and coverage policies so that each state program could be designed and tailored to respond to the needs in that state. Title XXI identified several minimum guidelines for SCHIP eligibility, but left considerable discretion to the states in how they could establish eligibility criteria and coverage policies within those minimum guidelines. Title XXI required states to maintain their Medicaid eligibility levels for children in effect as of June 1, 1997. It also authorized states to establish income eligibility levels for SCHIP up to 200 percent of poverty, or 50 percentage points above the Medicaid thresholds in effect on March 31, 1997. Title XXI provided states with the flexibility to determine how they would count income. Thus, states were able to set SCHIP thresholds above these limits through the use of income disregards, and several states have received approval to do so. Additionally, title XXI provided flexibility on several coverage-related policies, such as presumptive eligibility (at least initially), retroactive eligibility, or continuous eligibility, which had been used commonly by states in the Medicaid program in the past.

The title XXI legislation (section 2108(b)(1)(B)) required states to assess the characteristics of children assisted under SCHIP, including their ages, family income, the service area of the plan, and the time limits of coverage.[1] This chapter synthesizes information from the state evaluations concerning SCHIP eligibility criteria, namely SCHIP income thresholds, the extent to which SCHIP extended coverage beyond Medicaid, and the use of income disregards to adjust income. The chapter also examines state policies that affect the duration and continuity of coverage, including retroactive and presumptive eligibility, continuous eligibility, and frequency of redeterminations.

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[1] Another criterion for SCHIP eligibility is that the child must be uninsured at the time of application. Due to the concern that SCHIP coverage may substitute for private coverage, states that cover children to higher income levels, in particular, often focus on insurance coverage in the months prior to application. In Chapter VIII, we discuss the use of waiting periods without health insurance in conjunction with an analysis of state efforts to prevent crowd-out under SCHIP.

A. OVERVIEW OF SCHIP INCOME THRESHOLDS

As of March 31, 2001, 16 states had established eligibility thresholds below 200 percent of poverty; 25 states had established thresholds at 200 percent of poverty; and 10 states had thresholds above 200 percent of poverty (Table III.1). The average SCHIP income threshold, as of March 31, 2001, was 206 percent of poverty.

Title XXI limits eligibility to children under age 19 who are uninsured and not eligible for Medicaid. Since SCHIP was designed to build upon existing Medicaid coverage, the extent to which states could use SCHIP to significantly expand coverage depended in large part on whether they had instituted previous Medicaid eligibility expansions and, if so, the extent of those expansions. For example, because of previous Medicaid eligibility expansions for certain populations of children, Rhode Island, Wisconsin, and Wyoming used SCHIP to cover children ages six and older, while in Maine and South Carolina, SCHIP covers children over age one. Minnesota previously covered all children in Medicaid under age 18 up to 270 percent of poverty; the state elected to use SCHIP to expand coverage to 275 percent of poverty.

Nine states—Alabama, Arkansas, California, Florida, Mississippi, New York, North Dakota, Tennessee, and Texas—established M-SCHIP components to accelerate the mandated coverage of adolescents born before October 1, 1983 with family incomes below the poverty threshold (a mandate set forth in the Omnibus Budget Reconciliation Act (OBRA) of 1990). This phase-in of coverage was completed as of September 30, 2002, which means that by 2002, all children under

TABLE III.1

MEDICAID AND SCHIP INCOME THRESHOLDS, BY STATE

		Medicaid Thresholds as of March 31, 1997				SCHIP Thresholds as of March 31, 2001	
State	Program Type	Infants	Ages 1 through 5	Ages 6 through 16	Ages 17 through 18	M-SCHIP	S-SCHIP
		Percent of Federal Poverty Level					
Alabama[a]	COMBO	133	133	100	15	100	200
Alaska	M-SCHIP	133	133	100	71	200	-
Arizona	S-SCHIP	140	133	100	30	-	200
Arkansas[a,b]	M-SCHIP	133	133	100	18	100	-
California[a]	COMBO	200	133	100	82	100	250
Colorado	S-SCHIP	133	133	100	37	-	185
Connecticut	COMBO	185	185	185	100	185	300
Delaware	S-SCHIP	185	133	100	100	-	200
District of Columbia	M-SCHIP	185	133	100	50	200	-
Florida[a]	COMBO	185	133	100	28	100	200
Georgia[c]	S-SCHIP	185	133	100	100	-	200
Hawaii[d]	M-SCHIP	185	133	100	100	200	-
Idaho	M-SCHIP	133	133	100	100	150	-
Illinois[e]	COMBO	133	133	100	46	133	185
Indiana	COMBO	150	133	100	100	150	200
Iowa	COMBO	185	133	100	37	133	200
Kansas	S-SCHIP	150	133	100	100	-	200
Kentucky	COMBO	185	133	100	33	150	200
Louisiana[f]	M-SCHIP	133	133	100	10	150	-
Maine[g]	COMBO	185	133	125	125	150	185
Maryland[h]	M-SCHIP	185	185	185	40	200	-
Massachusetts[i]	COMBO	185	133	114	86	150	200
Michigan	COMBO	185	150	150	100	150	200
Minnesota[j]	M-SCHIP	275	275	275	275	280	-
Mississippi[a]	COMBO	185	133	100	34	100	200
Missouri	M-SCHIP	185	133	100	100	300	-
Montana	S-SCHIP	133	133	100	41	-	150
Nebraska	M-SCHIP	150	133	100	33	185	-
Nevada	S-SCHIP	133	133	100	31	-	200
New Hampshire[k]	COMBO	185	185	185	185	300	300
New Jersey	COMBO	185	133	100	41	133	350
New Mexico	M-SCHIP	185	185	185	185	235	-
New York[a,l]	COMBO	185	133	100	51	100	192
North Carolina	S-SCHIP	185	133	100	100	-	200
North Dakota[a,m]	COMBO	133	133	100	100	100	140
Ohio	M-SCHIP	133	133	100	33	200	-
Oklahoma[n]	M-SCHIP	150	133	100	48	185	-
Oregon	S-SCHIP	133	133	100	100	-	170
Pennsylvania	S-SCHIP	185	133	100	41	-	200
Rhode Island[o]	M-SCHIP	250	250	100	100	250	-

TABLE III.1 *(continued)*

		Medicaid Thresholds as of March 31, 1997				SCHIP Thresholds as of March 31, 2001	
State	Program Type	Infants	Ages 1 through 5	Ages 6 through 16	Ages 17 through 18	M-SCHIP	S-SCHIP
		Percent of Federal Poverty Level					
South Carolina	M-SCHIP	185	133	100	48	150	-
South Dakota	COMBO	133	133	100	100	140	200
Tennessee[a, p]	M-SCHIP	No limit	No limit	No limit	No limit	100	-
Texas[a]	COMBO	185	133	100	17	100	200
Utah	S-SCHIP	133	133	100	100	-	200
Vermont	S-SCHIP	225	225	225	225	-	300
Virginia	S-SCHIP	133	133	100	100	-	200
Washington	S-SCHIP	200	200	200	200	-	250
West Virginia	S-SCHIP	150	133	100	100	-	200
Wisconsin[q]	M-SCHIP	185	185	100	45	185	-
Wyoming[r]	S-SCHIP	133	133	100	55	-	133

SOURCE: SCHIP standards based on Mathematica Policy Research analysis of the title XXI State Evaluations, Table 3.1.1 of the State Evaluation Framework, and approved state amendments; Medicaid standards based on HCFA web site and Table 2 from HCFA's State Children's Health Insurance Program Annual Enrollment Report, October 1, 1998 - September 20, 1999.

NOTE: The type of SCHIP program is as of March 31, 2000. Title XXI stipulates that family income must exceed the Medicaid income level that was in effect on March 31, 1997 in order for a child to be eligible for SCHIP-funded coverage.

[a] In these states, the M-SCHIP component was designed to accelerate Medicaid coverage of children born before September 30, 1983. As of October 1, 2002, the M-SCHIP component will no longer exist, and the programs will become S-SCHIP only.

[b] Only children born after September 1, 1982, but before October 1, 1983, are eligible for M-SCHIP. Arkansas increased Medicaid eligibility to 200 percent of poverty, effective September 1997, through Section 1115 demonstration authority. Arkansas recently received approval to establish an S-SCHIP component that will cover children up to 200 percent of poverty. The state is awaiting approval to reduce the income threshold for its Medicaid 1115 demonstration program from 200 to 150 percent of poverty. This will effectively eliminate the M-SCHIP program.

[c] The S-SCHIP income threshold was raised to 235 percent of poverty in June 2001.

[d] Under a section 1115 Medicaid (title XIX) demonstration, eligibility for 17 and 18 year olds was set at 100 percent of poverty. However, from February 1, 1996 until January 2, 2001 enrollment within this age group was subject to an enrollment cap of 125,000. While the cap was in place, eligibility was restricted to 54 percent of poverty, the state's Medicaid eligibility threshold for this group of children.

[e] M-SCHIP covers infants up to 200 percent of poverty when the child is born to a woman in the Moms and Babies program.

[f] The M-SCHIP income threshold was raised to 200 percent of poverty in June 2001.

[g] The S-SCHIP income threshold was raised to 200 percent of poverty in March 2001.

[h] Prior to the implementation of SCHIP, Maryland provided a limited package of Medicaid benefits to children born after September 30, 1983, but at least 1 year of age, with family income up to 185 percent of poverty. Effective July 1, 2001, Maryland implemented an S-SCHIP component that extends coverage to children in families at or below 300 percent of poverty.

[i] M-SCHIP covers infants in families with income up to 200 percent of poverty.

[j] Only children ages 0 through 2 are eligible for M-SCHIP.

[k] Infants are covered through M-SCHIP, and children ages 1 through 18 are covered through S-SCHIP.

[l] In July 2001, the S-SCHIP income threshold was raised to 200 percent of poverty and the effective income eligibility level was raised to 250 percent of poverty through the use of income disregards.

[m] The Medicaid thresholds apply to children under 18 years of age. The M-SCHIP program covers only 18-year-olds.

[n] M-SCHIP covers children through age 17.

[o] The Rhode Island Medicaid program covers children ages 0 through 7 to 250 percent of poverty, and children 8 and older to 100 percent of poverty. An amendment to increase the M-SCHIP income threshold to 300 percent of poverty has been approved, but not implemented.

[p] Under its section 1115 Medicaid demonstration, Tennessee has no upper eligibility level. The currently approved title XXI plan covers children born before October 1, 1983, in the expansion group and who enrolled in TennCare on or after April 1, 1997. TennCare recipients with income above the poverty level are charged a monthly premium based on a sliding scale. Premium subsidies end when income reaches 400 percent of poverty.

[q] Once a child is enrolled, eligibility is maintained as long as income stays below 200 percent of poverty.

[r] The S-SCHIP income threshold was raised to 150 percent of poverty in June 2001.

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age 19 who are below poverty will be covered by Medicaid. Therefore, unless these nine states amend the eligibility criteria for their M-SCHIP components, the M-SCHIP components in these states will end on September 30, 2002, since all children younger than 19 years old with family income below the poverty threshold will become eligible for Medicaid.

Title XXI permits states to amend their programs as needed. As a result, states have amended their program structure and income thresholds over time. Two states chose to amend their SCHIP programs to phase out their M-SCHIP component and extend eligibility through an S-SCHIP program. West Virginia, for example, expanded coverage from 150 to 200 percent of poverty; it also discontinued the M-SCHIP component of its program and transferred the M-SCHIP children to its S-SCHIP program.

Since initial implementation, 23 states have raised their SCHIP eligibility thresholds. Of these 23 states, 14 expanded eligibility within an existing SCHIP program; 5 phased in an S-SCHIP component after initially implementing an M-SCHIP component; and 4 used both approaches to extend eligibility. Only one state, Idaho, has decreased its SCHIP income threshold (from 160 percent to 150 percent of poverty).

States continue to modify the eligibility levels for their SCHIP programs. Since March 2001, for example, Georgia increased eligibility in its S-SCHIP program from 200 to 235 percent of poverty. Maine raised its S-SCHIP threshold from 185 to 200 percent of poverty. Maryland implemented an S-SCHIP component that covers children in families with income between 200 and 300 percent of poverty. New York increased the net income threshold from 192 to 200 percent of poverty for its S-SCHIP program, effectively increasing eligibility to 250 percent of poverty through the use of income disregards. Finally, Wyoming expanded S-SCHIP eligibility from 134 to 150 percent of poverty.

B. THE EXTENT OF SCHIP EXPANSIONS BEYOND MEDICAID

In many states, SCHIP represents a significant expansion of publicly financed insurance coverage for children. The level of coverage expansion brought about by title XXI is a function, not only of the upper income eligibility for SCHIP within a state, but also the "floor" where Medicaid coverage stops and SCHIP coverage begins. Because Medicaid thresholds vary across states—and, typically, across age groups within a state—the expansiveness of SCHIP can vary considerably across states and age groups.[2]

Figure III.1 depicts how the extent of the expansion of coverage under SCHIP varies by age. On average, SCHIP raised income thresholds by 61 percentage points among children ages 1 through 5, but among older adolescents (ages 17 and 18), SCHIP expanded coverage by an average of 129 percentage points. Equally important, SCHIP has enabled states to minimize the impact of the traditional "stairstep" approach to eligibility under Medicaid that, in most states, left some children within a low-income family without coverage.

Take the example of a state that, prior to SCHIP, covered children under Medicaid only to mandatory levels and that extended coverage to 150 percent of poverty under SCHIP. Prior to SCHIP, a family with income at 120 percent of poverty and two children—ages 4 and 12—would only qualify for coverage for the 4-year-old. Following the implementation of SCHIP, all

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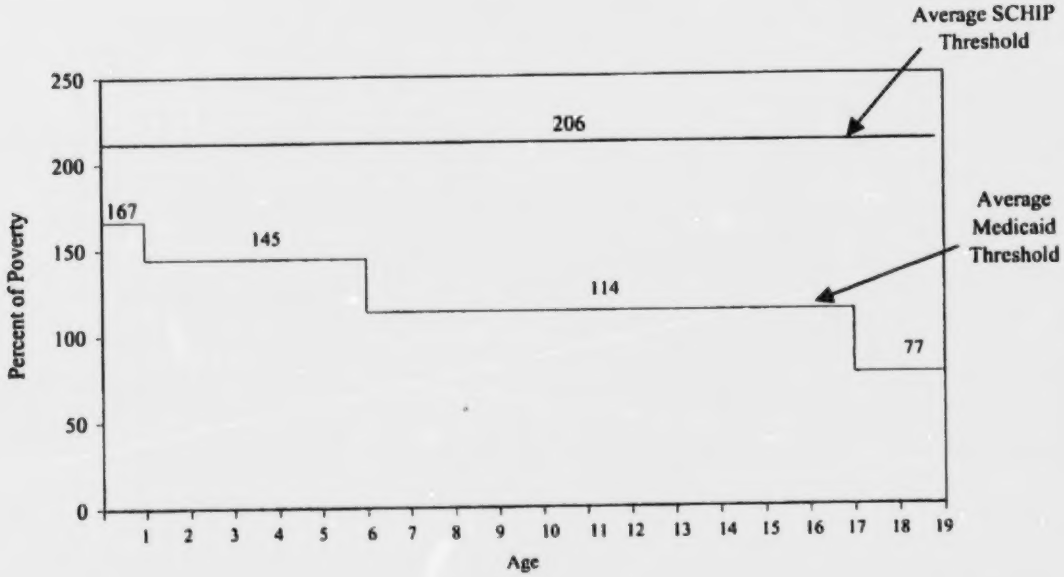
[2] State Medicaid programs are mandated to cover children under age six who are under 133 percent of poverty, and children six years and older (born after September 30, 1983) who are under 100 percent of poverty. It may be higher in some states if, as of certain dates, the state had established a higher eligibility level. Medicaid programs also have the option of covering children born on or before September 30, 1983, up to 100 percent of poverty. States have other options as well. They can cover infants to 185 percent of poverty. The section 1902(r)(2) provisions of the Social Security Act and section 1115 demonstrations are other mechanisms allowing states to extend Medicaid beyond Federal requirements.

FIGURE III.I

MEDICAID AND SCHIP AVERAGE ELIBIGILITY THRESHOLDS BASED ON
FAMILY INCOME AS A PERCENTAGE OF THE FEDERAL POVERTY LEVEL,
AS OF MARCH 31, 2001



SOURCE: Mathematica Policy Research analysis of medicaid and SCHIP thresholds as reported in the title XXI State Evaluations, Annual Reports, and HCFA's State Children's Health Insurance Program Annual Enrollment Report, October 1, 1998 - September 20, 1999.

NOTE: The average Medicaid thresholds are based on the thresholds in place on March 31, 1997.

children under age 19 in the family would now be eligible for coverage—either under Medicaid or SCHIP.

In 40 states, SCHIP expanded coverage by at least 100 percentage points among older adolescents, and in 28 states, coverage expanded by 100 percentage points or more for children ages 6 through 16. The expansion of eligibility to adolescents is important, because this group was more likely to lack insurance coverage at the time SCHIP was enacted (U.S. Census Bureau 1998).

To better understand the extent of the eligibility expansions under SCHIP, states can be examined along two dimensions: (1) the absolute level of their SCHIP income thresholds as of March 31, 2001; and (2) the level of the expansion relative to eligibility thresholds under the Medicaid program in place as of March 31, 1997. Both dimensions are important in understanding the extent of SCHIP coverage expansions within each state. Table III.2 classifies states according to these two dimensions. The columns reflect the absolute level of each state's SCHIP income threshold as of March 31, 2001: at or below 150 percent of poverty (8 states); between 150 and 200 percent of poverty (8 states); at 200 percent of poverty (25 states); or above 200 percent of poverty (10 states).

The rows in Table III.2 reflect the extent to which SCHIP has allowed states to extend eligibility for publicly financed health insurance coverage beyond the thresholds set by Medicaid as of March 31, 1997. Narrow expansions reflect increases of less than 50 percentage points in all age categories, or at least a 50 percentage point increase in one age category only (6 states); intermediate expansions reflect increases of at least 50 percentage points in two age categories (7 states); and broad expansions reflect increases of at least 50 percentage points in three or four age categories (38 states).

TABLE III.2

ABSOLUTE AND RELATIVE LEVELS OF INCOME THRESHOLDS UNDER SCHIP, AS OF MARCH 31, 2001

Level of SCHIP Income Thresholds Relative to Medicaid	Absolute Level of SCHIP Income Thresholds			
	At or below 150 percent of poverty (N = 8)	151 to 200 percent of poverty (N = 8)	At 200 percent of poverty (N = 25)	Over 200 percent of poverty (N = 10)
Narrow (N=6)	Arkansas[a] North Dakota Tennessee[a] Wyoming		Maryland[a,b]	Minnesota[a]
Intermediate (N = 7)	Idaho Louisiana Montana South Carolina	Oregon Wisconsin		Rhode Island[b]
Broad (N = 38)		Colorado Illinois Maine[b] Nebraska New York Oklahoma	Alabama Alaska Arizona Delaware District of Columbia Florida Georgia Hawaii Indiana Iowa Kansas Kentucky Massachusetts Michigan Mississippi Nevada North Carolina Ohio Pennsylvania South Dakota Texas Utah Virginia West Virginia	California Connecticut Missouri New Hampshire New Jersey New Mexico Vermont Washington

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations.

NOTE: The relative level of SCHIP income thresholds reflects the magnitude of the expansion relative to traditional Medicaid across four age categories: less than 1 year, 1 through 5, 6 through 16, and 17 through 18.

[a] These states covered children to a high income level under Medicaid prior to SCHIP. As a result, SCHIP programs in these states are small. The section 1115 Medicaid demonstration program in Arkansas currently provides coverage through 200 percent of poverty. This threshold will be lowered to 150 percent of poverty when Arkansas implements its S-SCHIP component, which will cover children through 200 percent of poverty. The Tennessee Medicaid demonstration program does not base eligibility on income. The Medicaid program in Maryland covers children born after September 30, 1983 up to 185 percent of poverty, while Minnesota's Medicaid program covers all children under age 19 up to 275 percent of poverty.

[b] These states expanded SCHIP eligibility after March 31, 2001, or have approval to expand the SCHIP income threshold. See Table III.1 for details.

Narrow = Increased coverage by less than 50 percentage points or increased coverage by at least 50 percentage points for one age category

Intermediate = Increased coverage by at least 50 percentage points for two age categories

Broad = Increased coverage by at least 50 percentage points for three or four age categories

The taxonomy shows wide variation among states in the level of the expansion under SCHIP. Three states that implemented Medicaid expansions through section 1115 demonstration programs—Arkansas, Minnesota, and Tennessee—highlight the important relationship between the income thresholds used by Medicaid and SCHIP programs. Before the enactment of SCHIP, these states had already established income eligibility thresholds for Medicaid that are comparable to those currently used by SCHIP programs in other states. In these three states, SCHIP fills the limited remaining gaps for specific age or income groups; consequently, enrollment has been relatively small. Two other states—North Dakota and Wyoming—opted for narrow expansions, raising SCHIP eligibility to 140 and 133 percent of poverty, respectively.

Seven other states have undertaken modest expansions under SCHIP. The SCHIP programs in Rhode Island and Wisconsin expanded coverage for children six years of age and older. These states had previously established high Medicaid thresholds for younger children, and therefore used SCHIP to extend eligibility to older children (up to 250 and 185 percent of poverty, respectively). Similarly, the program in South Carolina targeted children over age six by raising the eligibility threshold to 150 percent of poverty. The SCHIP programs in Idaho, Louisiana, Montana, and Oregon modestly expanded eligibility for children of all ages, although the extent of the expansion varied by state.

Of the 38 states that implemented broad expansions through SCHIP, 32 targeted families with incomes at or above 200 percent of poverty.[3] All but eight of these states established S-SCHIP programs, either alone or in combination with M-SCHIP programs. The broad SCHIP expansions in Connecticut, Missouri, New Hampshire, and New Jersey extended eligibility by more than 100 percentage points above the Medicaid thresholds for children of all ages. For example, based on the Medicaid thresholds in place as of March 31, 1997, New Jersey's SCHIP program expanded coverage by 165 percentage points for infants, 217 percentage points for children ages 1 through 5, 250 percentage points for children ages 6 through 16, and 309 percentage points for adolescents ages 17 and 18.

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[3] Another three states set their SCHIP thresholds at or above 200 percent of poverty, but these states had implemented more modest expansions of eligibility under SCHIP, relative to their Medicaid thresholds (Maryland, Minnesota, and Rhode Island).

Another three states—New Mexico, Vermont, and Washington—used SCHIP to further enhance existing Medicaid coverage levels; by March 1997, these states had established Medicaid thresholds that were uniform and above the mandated levels for all age groups (185, 225, and 200 percent of poverty, respectively). These states took advantage of the flexibility under title XXI to extend coverage to higher income levels by establishing SCHIP thresholds at least 50 percentage points above their Medicaid thresholds.

C. USE OF NET INCOME TESTS TO ADJUST INCOME

How a state elects to count income is crucial to understanding which children are eligible for SCHIP coverage in a given state. Title XXI allows states to adjust family income before determining eligibility—using what is known as a net-income test—to ascertain whether the family qualifies for the program. States using net-income tests apply disregards, which are deductions from a family's gross income, for items such as child care expenses, work deductions, or child support or alimony. This "disregarding" of portions of income effectively allows a state to cover individuals with higher gross incomes under their SCHIP programs.

Forty states reported using net-income tests, 6 states used gross-income tests, and 4 states used both gross- and net-income tests (Table III.3). The four states that used both tests operate

TABLE III.3

SCHIP INCOME TESTS AND THRESHOLDS, BY STATE

		M-SCHIP		S-SCHIP	
State	Program Type	Type of Income Test	Income Threshold	Type of Income Test	Income Threshold
Alabama	COMBO	Net	100	Gross	200
Alaska	M-SCHIP	Net	200	-	-
Arizona	S-SCHIP	-	-	Net	200
Arkansas	M-SCHIP	Net	100	-	-
California	COMBO	Net	100	Net	250
Colorado	S-SCHIP	-	-	Net	185
Connecticut	COMBO	Net	185	Net	300
Delaware	S-SCHIP	-	-	Net	200
District of Columbia	M-SCHIP	Net	200	-	-
Florida	COMBO	Net	100	Gross	200
Georgia	S-SCHIP	-	-	Net	200
Hawaii	M-SCHIP	Net	200	-	-
Idaho	M-SCHIP	Gross	150	-	-
Illinois	COMBO	Net	133	Net	185
Indiana	COMBO	Net	150	Net	200
Iowa	COMBO	Net	133	Net	200
Kansas	S-SCHIP	-	-	Net	200
Kentucky	COMBO	Net	150	Net	200
Louisiana	M-SCHIP	Net	150	-	-
Maine	COMBO	Net	150	Gross	185
Maryland	M-SCHIP	Net	200	-	-
Massachusetts	COMBO	Gross	150	Gross	200
Michigan	COMBO	Net	150	Net	200
Minnesota	M-SCHIP	Net	280	-	-
Mississippi	COMBO	Net	100	Net	200
Missouri	M-SCHIP	Gross	300	-	-
Montana	S-SCHIP	-	-	Net	150
Nebraska	M-SCHIP	Net	185	-	-
Nevada	S-SCHIP	-	-	Gross	200
New Hampshire	COMBO	Net	300	Net	300
New Jersey	COMBO	Net	133	Gross[a]	350
New Mexico	M-SCHIP	Net	235	-	-
New York	COMBO	Net	100	Net	192
North Carolina	S-SCHIP	-	-	Net	200
North Dakota	COMBO	Net	100	Net	140
Ohio	M-SCHIP	Net	200	-	-
Oklahoma	M-SCHIP	Net	185	-	-
Oregon	S-SCHIP	-	-	Gross	170
Pennsylvania	S-SCHIP	-	-	Net	200
Rhode Island	M-SCHIP	Net	250	-	-
South Carolina	M-SCHIP	Net	150	-	-
South Dakota	COMBO	Net	140	Net	200
Tennessee	M-SCHIP	Gross	100	-	-
Texas	COMBO	Net	100	Net	200
Utah	S-SCHIP	-	-	Net	200
Vermont	S-SCHIP	-	-	DNR	300
Virginia	S-SCHIP	-	-	Net	200
Washington	S-SCHIP	-	-	Net	250
West Virginia	S-SCHIP	-	-	Net	200
Wisconsin	M-SCHIP	Net	185	-	-
Wyoming	S-SCHIP	-	-	Net	133

SOURCE: Mathematica Policy Research analysis of the title XXI State Evaluations, Table 3.1.1 and the Addendum to Table 3.1.1 of the State Evaluation Framework, and Annual Reports for 2000.

NOTE: The type of SCHIP program is as of March 31, 2001. The state evaluations generally present program characteristics as of September 30, 1999.

[a] If gross income is at or above 200 percent of poverty, the New Jersey S-SCHIP program disregards all income up to 350 percent of poverty.

DNR = Did Not Report

combination SCHIP programs: the M-SCHIP component used a net-income test, while the S-SCHIP component used a gross-income test.

How states calculate net income is extremely complex and highly variable. The state evaluations illustrate the range and variation of disregards used by states to adjust income in determining eligibility for SCHIP. These disregards typically excluded a portion of earnings, child support payments received, and child care expenses.

- ***Earnings Disregards***. Of the 45 states reporting information about their income disregards, 20 states disregarded $90 per earner per month from income for work-related expenses. In South Carolina, the earnings disregard was $100 per month per working parent; Montana and Texas disregarded $120 per earner; Kansas disregarded $200; and Wyoming disregarded $200 if the family had one parent with earnings, or $400 if there were two parents with earnings. Other SCHIP programs disregarded a fixed portion of earnings: Iowa and Nebraska disregarded 20 percent of earnings; Delaware disregarded 50 percent of parental income if the household included a pregnant teen; and South Dakota disregarded either $90 per month or 20 percent of earnings, whichever was larger.
- ***Child Support and Child Care Disregards***. Typically, states disregarded $50 per month for child support payments and $175 per month for child care expenses ($200 if the child was under two years of age). However, some states (such as Alaska, Colorado, and New Mexico) disregarded all child support payments. Other states (such as Colorado, District of Columbia, Nebraska, North Dakota and South Dakota) disregarded all child care expenses.[4]
- ***Other Disregards.*** The SCHIP programs in Colorado, Nebraska, and North Dakota disregarded all out-of-pocket medical care expenses, including health insurance premiums. In North Dakota, medical care expenses included expenses for transportation, remedial services, long-term care insurance premiums, and adult dependent care services.

In comparing income thresholds among SCHIP programs, it is important to keep in mind whether states use a net- or gross-income test in determining eligibility. This is because states using a net-income test disregard a portion of income, so the actual gross income of the family may be higher than in states using a straight gross-income test. In New Jersey's SCHIP program, for example, the state used a net-income test for Plan A (an M-SCHIP plan that covers children up to 133 percent of poverty) and a gross-income test for Plan B (an S-SCHIP plan that covers children up to 150 percent of poverty). The State expected Plan B to have low enrollment, since most children would become eligible for Plan A based on the net-income test. Among M-SCHIP programs that set their eligibility thresholds at 150 percent of poverty, two states that used gross-income tests (Massachusetts and Idaho) had lower effective income cut-offs than those that used net-income tests (Indiana, Kentucky, Louisiana, Maine, Michigan, and South Carolina). Similarly, among the three states that set eligibility thresholds at 300 percent of poverty, the effective income threshold was higher in Connecticut and New Hampshire, which used net-income tests, than in Missouri, which used a gross-income test.

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[4] South Dakota disregarded all child care expenses for applicants to the M-SCHIP component, but disregarded a maximum of $500 for applicants to the S-SCHIP component.

D. OTHER CRITERIA USED TO DETERMINE ELIGIBILITY FOR SCHIP

1. Use of Asset Tests

The use of asset tests has a long history in welfare and Medicaid programs. In an effort to simplify the eligibility determination process, a number of state Medicaid programs began in the late 1980s to eliminate asset tests for certain Medicaid populations, such as pregnant women and children. The title XXI statute did not address the use of asset tests, allowing states the flexibility to determine whether to require an asset test as a condition of eligibility.[5]

Only five states reported using asset tests in their SCHIP programs (Arkansas, Indiana, North Dakota, Oregon, and Texas). In these states, children might not qualify for SCHIP coverage if the value of family assets was above a set limit, even though a child qualified for

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[5] However, the implementing regulations for the program strongly encouraged states not to require an asset test, as a means to simplify the eligibility determination process and facilitate enrollment of children into the program.

SCHIP on the basis of family income. In two of these states, North Dakota and Texas, the asset test applied only to the M-SCHIP component of their programs.

Another four states used asset tests in their traditional Medicaid programs, but not in their SCHIP programs (Colorado, Montana, Nevada, and Utah). In these states, SCHIP programs were likely to enroll some children who had family incomes below the Medicaid threshold, but assets that rendered them ineligible for Medicaid coverage.

2. Service Area and Residency Requirements

Unlike traditional Medicaid, title XXI provided states with the flexibility to define the service area for the program and residency requirements. All SCHIP programs operated on a statewide basis, with the exception of Florida's Healthy Kids program, which served 60 of the state's 67 counties as of January 1, 2000. Most states required enrollees to be state residents, although some simply required enrollees to be living in the state with the intent to remain indefinitely—for example, those who came to a state with a job offer or to seek employment (Alaska, Iowa, Texas, Utah, and Washington). Pennsylvania required 30 days of state residency. Nevada initially required a six-month residency period before children could qualify, but eliminated this requirement in April 2000. Michigan and Wisconsin noted that they covered children in migrant families.[6]

E. OTHER POLICIES THAT AFFECT TIME LIMITS FOR COVERAGE

The title XXI statute (section 2108(b)(1)(B)(v)) required states to assess the design elements of their SCHIP programs that affect "time limits" for coverage. These design elements include retroactive coverage and presumptive eligibility, as well as continuous coverage and the frequency of redeterminations. The first two design elements allow states to expedite the initiation of coverage, and protect providers from uncompensated care costs and families from costs of medical bills. The other two strategies may allow states to promote continuity of care and facilitate retention.

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[6] The SCHIP regulations, effective August 24, 2001, do not allow states to impose a durational residency requirement. States were required to comply with this requirement as of August 24, 2001.

1. Retroactive Eligibility

Medicaid requires states to provide up to three months of retroactive eligibility. Once a child is determined eligible for Medicaid coverage, the state must also determine whether the child would have been eligible during the three months before the date of application, if they had applied. If the child appears to have been eligible and received Medicaid-covered services during any of those months, Medicaid will pay for any bills that remain unpaid. In addition to assisting families with unpaid medical bills, retroactive eligibility offers some protection to providers against uncompensated care provided to uninsured, low-income children. Because states with M-SCHIP components must comply with all Medicaid requirements, all states with M-SCHIP programs provide three months of retroactive eligibility. Title XXI did not include a requirement that states offering S-SCHIP programs must offer retroactive eligibility.

With a few exceptions, states with S-SCHIP programs reported that they did not offer retroactive eligibility (Table III.4).

- Kentucky and Massachusetts reported offering retroactive eligibility under both their M-SCHIP and S-SCHIP components. Kentucky offered three months of retroactive coverage if the applicant lived in a region that did not have managed care. In regions with managed care, eligibility dated back to the first day of the month that the application was received. In Massachusetts, children could receive up to 10 days of eligibility retroactive to the date an application was received by the MassHealth Enrollment Center or an outreach site, but only when all required verifications had been submitted within 60 calendar days of the information requested. The only exception was verification of immigration status.

TABLE III.4

THE USE OF RETROACTIVE, PRESUMPTIVE, AND CONTINUOUS ELIGIBILITY, AND THE FREQUENCY OF REDETERMINATIONS, BY STATE

State	Program Type	Retroactive Eligibility	Presumptive Eligibility	Continuous Eligibility	Frequency of Redeterminations
Alabama	COMBO	3 months[a]	No	12 months	12 months
Alaska	M-SCHIP	3 months	No	6 months	6 months
Arizona	S-SCHIP	No	No	12 months	12 months
Arkansas	M-SCHIP	3 months	No	No	12 months
California	COMBO	3 months[a]	No	12 months[b]	12 months[b]
Colorado	S-SCHIP	Date of application[c]	No	12 months	12 months
Connecticut	COMBO	3 months[a]	No	12 months	12 months[b]
Delaware	S-SCHIP	No	No	12 months[d]	12 months
District of Columbia	M-SCHIP	3 months	No	No	12 months
Florida	COMBO	3 months[a]	No	6 months[e]	6 months[e]
Georgia	S-SCHIP	No	No	No	12 months
Hawaii	M-SCHIP	3 months[f]	No	No	12 months
Idaho	M-SCHIP	3 months	No	12 months	12 months
Illinois	COMBO	3 months[a,g]	No	12 months	12 months[b]
Indiana	COMBO	3 months[a]	No	12 months[d]	12 months
Iowa	COMBO	3 months[a]	No	12 months[b]	12 months[b]
Kansas	S-SCHIP	No	No	12 months	12 months
Kentucky	COMBO	3 months[h]	Yes[i]	6 months[j]	12 months
Louisiana	M-SCHIP	3 months	No	12 months	12 months
Maine	COMBO	3 months[a]	Yes[k]	6 months	6 months
Maryland	M-SCHIP	3 months	No	6 months[l]	12 months
Massachusetts	COMBO	10 days	Yes	No	12 months
Michigan	COMBO	3 months[a]	Yes[m]	12 months[b]	12 months
Minnesota	M-SCHIP	3 months	No	No	12 months
Mississippi	COMBO	3 months[a]	No	12 months	12 months
Missouri	M-SCHIP	No	No	No	12 months
Montana	S-SCHIP	No	No	12 months	12 months
Nebraska	M-SCHIP	3 months	Yes	12 months	12 months
Nevada	S-SCHIP	Date of birth[n]	No	12 months[n]	12 months[n]
New Hampshire	COMBO	3 months[a]	Yes[o]	6 months	12 months
New Jersey	COMBO	3 months[a]	Yes	No	12 months[b]
New Mexico	M-SCHIP	3 months	Yes	12 months	12 months
New York	COMBO	3 months[a]	Yes[p]	12 months[q]	12 months
North Carolina	S-SCHIP	No	No	12 months	12 months
North Dakota	COMBO	3 months[a]	No	12 months[b]	12 months[b]
Ohio	M-SCHIP	3 months	No	No[r]	6 months[r]
Oklahoma	M-SCHIP	3 months	No	6 months	6 months
Oregon	S-SCHIP	No	No	6 months	6 months
Pennsylvania	S-SCHIP	No	No	12 months	12 months
Rhode Island	M-SCHIP	3 months[a]	No	6 months[l]	12 months
South Carolina	M-SCHIP	3 months	No	12 months	12 months
South Dakota	COMBO	3 months	No	No	12 months
Tennessee	M-SCHIP	No	No	12 months	12 months
Texas	COMBO	3 months[a]	No	12 months[b]	12 months
Utah	S-SCHIP	No	No	12 months	12 months

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TABLE III.4 *(continued)*

	Program Type	Retroactive Eligibility	Presumptive Eligibility	Continuous Eligibility	Frequency of Redeterminations
Vermont	S-SCHIP	3 months	No	6 months[l]	6 months
Virginia	S-SCHIP	No	No	No	12 months
Washington	S-SCHIP	First of the month in which application is received	No	12 months[m]	12 months
West Virginia	COMBO	No	No	12 months[b]	12 months[b]
Wisconsin	M-SCHIP	No	No	No	12 months
Wyoming	S-SCHIP	First of the month in which application is received	No	12 months	12 months

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations, Sections 3.1.3 - 3.1.4 of the State Evaluation Framework, and Annual Reports for 2000.

NOTE: The type of SCHIP program is as of March 31, 2001. The state evaluations generally present program characteristics as of September 30, 1999.

[a] M-SCHIP only. The M-SCHIP program in Connecticut only has retroactive eligibility for newborns to the date of birth and only if an application is filed within 30 days of birth. In Indiana retroactive eligibility for S-SCHIP coverage is available to the first day of the month of application, once the first premium has been paid.

[b] S-SCHIP only. The M-SCHIP program in California redetermines eligibility quarterly, in Iowa the frequency varies by the family's recent earnings history and the stability of earnings, while in North Dakota the M-SCHIP component has a monthly redetermination process. The M-SCHIP programs in New Jersey and West Virginia redetermine eligibility every six months.

[c] Applies only to children who applied first to Medicaid.

[d] Applies only if monthly premiums are paid. In Indiana, continuous coverage does not apply when the child obtains creditable private insurance coverage.

[e] The CMS program has 12-month continuous coverage and annual redeterminations.

[f] Only for blind/disabled children in fee for service.

[g] First time enrollees in S-SCHIP are retroactively eligible for coverage for the two weeks prior to application and until coverage begins.

[h] Only if living in a region without a managed care partnership, otherwise eligibility is only retroactive to the first day of the month of application.

[i] Approved, but not implemented.

[j] Only applies if living in a region covered by a managed care partnership.

[k] Pregnant teens only.

[l] Applies only to the initial enrollment period.

[m] At the option of S-SCHIP managed care organizations, but none have exercised this option.

[n] Infants only.

[o] Prior to May 4, 2000, all children were redetermined on October 1 of each year for 12 continuous months of eligibility. Currently, 12-month continuous coverage and annual redeterminations are based on the child's date of enrollment.

[p] Infants only. Applies only to the M-SCHIP component.

[q] Only for S-SCHIP and children may have only one period of presumptive eligibility.

[r] If a family also participates in the Food Stamp program, then redeterminations occur every three months when Food Stamp eligibility is redetermined. Ohio has submitted an 1115 waiver application for 12-month continuous coverage for children with family income between 150 and 200 percent of poverty.

[s] Only for recipients in fee-for-service.

[t] Applies only to initial enrollment in managed care.

[u] Applies unless the family fails to pay SCHIP premiums for four months or the child becomes Medicaid eligible.

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- Washington and Wyoming indicated that SCHIP eligibility was retroactive to the first of the month in which the application was received. The S-SCHIP program in Colorado provided retroactive eligibility back to the date of application for children who applied first to Medicaid.
- The S-SCHIP program in Nevada provided retroactive eligibility back to the month of birth for infants whose siblings were currently enrolled in SCHIP or whose mothers were current SCHIP enrollees. Exceptions applied if the mother failed to inform the program of her pregnancy prior to birth, or if the adult mother had health insurance that covered the infant for the first 30 days of life.

2. Presumptive Eligibility

Presumptive eligibility allows designated providers to enroll children temporarily when family income appears to qualify the child for coverage, until a full determination of eligibility can be made. Presumptive eligibility allows an individual to immediately access needed health care services and offers some protection for health care providers from bearing the costs of uncompensated care. Presumptive eligibility has been an option for traditional Medicaid programs for many years.

States indicated in their state evaluations that they had little incentive to implement presumptive eligibility under SCHIP because of certain regulatory provisions.[7] Nine states reported offering presumptive eligibility under SCHIP, and in most of these states, it was offered only for a subgroup of children.

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[7] The title XXI statute was not clear about how states with S-SCHIP programs that offered presumptive eligibility would be reimbursed for such costs. The SCHIP proposed rule, which was issued in the *Federal Register* on November 8, 1999, explained that, if the child was found ineligible for Medicaid or SCHIP, the costs incurred during periods of presumptive eligibility were applied to the 10 percent administrative cap. The Benefits Improvement and Protection Act (BIPA) of 2000 clarified that S-SCHIP programs could presumptively enroll children and that costs incurred during a period of presumptive eligibility, should the child be found ineligible for SCHIP or Medicaid, were not subject to the 10 percent administrative cap. The SCHIP final rule, issued January 11, 2001, incorporated this clarification.

- Massachusetts and New Jersey were the only states that offered presumptive eligibility for all SCHIP applicants. In New Jersey, acute care hospitals, Federally Qualified Health Centers, and local health departments were allowed to presumptively enroll children in SCHIP if gross family income did not exceed 200 percent of poverty.
- Maine had presumptive eligibility for pregnant teens only, and New Hampshire provided it only for infants covered under its M-SCHIP component. In New York, presumptive eligibility was provided only by its S-SCHIP component, and children were only eligible for one period of presumptive eligibility.
- In Michigan, presumptive eligibility was at the option of each managed care organization; as of September 30, 2000, none had used this option.

3. Frequency of Redeterminations and Continuous Eligibility

Various studies have documented the benefits of continuous insurance coverage on the quality of care children received (Berman et al. 1999; Christakis et al. 2001; Kogan et al. 1995; and Almeida and Kenney 2000). These studies found that when insurance coverage is stable, a child is more likely to have a "medical home" and to receive timely and continuous care. This logic has been applied to public programs, such as SCHIP and Medicaid, and states have been encouraged to adopt policies that would facilitate retention of children in their programs.

Twenty-nine states reported using annual redeterminations and offering 12 months of continuous eligibility, but this coverage was not extended to all children in 8 of these states. Four states with combination programs (California, Iowa, North Dakota, and West Virginia) offered both annual redeterminations and 12 months of continuous eligibility to children in their S-SCHIP programs, but not those enrolled in M-SCHIP. Another four states with combination programs had annual redeterminations for both their S-SCHIP and M-SCHIP programs, but offered 12 months continuous eligibility to their S-SCHIP children only (Delaware, Illinois, Michigan, and Texas).

Another group of 15 states redetermined eligibility annually, but had more limited policies with regard to continuous eligibility. Four of these states provided six months of continuous coverage, while the other 11 provided no guarantee of continuous eligibility. In these 11 states, families were required to report income and family structure changes when they occurred between eligibility determinations.

The remaining seven states that determined eligibility more frequently than every 12 months generally used redetermination periods of 6 months in their SCHIP programs. Four of these seven states extended six-month continuous eligibility to all SCHIP enrollees.

In a few states, the redetermination and continuous-eligibility policies were somewhat unusual, or they had some interesting ancillary requirements.

- For its M-SCHIP program, North Dakota required eligibility to be redetermined every month and there was no guarantee of continuous eligibility. However, for its S-SCHIP program, redetermination occurred annually, and continuous eligibility was guaranteed for 12 months.
- Although Ohio generally used a six-month redetermination period for its M-SCHIP program, redeterminations could be as frequent as every three months when food stamps eligibility was involved.
- In Delaware, Indiana, and Washington, premium payments had to be up-to-date for a child to qualify for continuous eligibility. Continuous eligibility also no longer applied when a child became eligible for private coverage in Indiana or for Medicaid in Washington.
- In Kentucky and Vermont, 6-month continuous eligibility was available only to children in managed care.
- In Maryland and Rhode Island, 6-month continuous eligibility was available only for the initial enrollment period.

Policies on the frequency of redeterminations and continuous eligibility may have an impact on children's enrollment patterns under SCHIP. MPR will conduct research in the future that examines the effects of SCHIP eligibility and coverage policies on retention and turnover.

F. CONCLUSION

SCHIP represents an important extension of insurance coverage beyond traditional Medicaid. Title XXI provided states with the opportunity and the flexibility to expand coverage to populations of children that previous expansions of Medicaid had not addressed. Adolescents, in particular, have benefited from coverage expansions enacted under SCHIP. Not only did low-income adolescents have the highest uninsured rate pre-SCHIP, but they also were the least likely to be eligible for traditional Medicaid. On average, SCHIP raised income thresholds by 61 percentage points among children ages 1 through 5, but among older adolescents (ages 17 and 18), SCHIP expanded coverage by an average of 129 percentage points.

States have used the flexibility offered by title XXI to structure and restructure their programs as needed to accommodate the populations in the state requiring coverage. Income thresholds have been dynamic, and most states have amended their programs to extend eligibility to higher income thresholds. States have coupled eligibility expansions with policies to simplify eligibility determination, such as eliminating the use of an asset test (only five states reported using an asset test in SCHIP), and improve the continuity of coverage, such as provisions for 12-month continuous eligibility. More than half the states guaranteed coverage for 12 months, although some states did not offer continuous coverage to all their SCHIP enrollees. Nine states reported offering presumptive eligibility under SCHIP, which allows an individual to immediately access needed health care services and offers some protection for enrollees and health care providers from bearing the costs of uncompensated care.

State eligibility and coverage policies are continuing to evolve. In addition to continuing to cover children, states have expressed an interest in using SCHIP funds to cover other populations such as parents and pregnant women. Six states have received approval under SCHIP section 1115 demonstrations to cover adults under SCHIP. It remains to be seen whether slowdowns in the economy will have any impact on states' ability to support SCHIP eligibility expansions in the future.

IV. SCOPE OF BENEFITS AND COST-SHARING REQUIREMENTS

The diversity of state approaches to designing and implementing SCHIP is reflected not only in states' eligibility and coverage policies, but in their scope of benefits and cost-sharing requirements as well. Title XXI gave states flexibility—within certain constraints—to develop benefit packages consistent with that offered in the public or private insurance markets. Title XXI also gave states the flexibility to require cost sharing of enrollees, but this flexibility was also governed by some general parameters. The degree of autonomy varies, depending on the structure of a state's SCHIP program (that is, S-SCHIP or M-SCHIP).

In designing a benefit package, states with an M-SCHIP program must offer enrollees the same benefit package as mandated for Medicaid. M-SCHIP programs, therefore, must provide the traditional Medicaid benefit package to children under age 21: inpatient and outpatient hospital services, emergency room services, physician services, laboratory and X-ray services, family planning services, dental (medical and surgical) services, well-baby and well-child visits, immunizations, prescription medications, and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.[1] States may cover such optional services as intermediate care facilities for the mentally retarded, optometrist services and eyeglasses, and nonmedical dental services.

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[1] Under Federal law, states are required to provide EPSDT services to all Medicaid children up to age 21. Services include age-appropriate screenings, vision, dental, and hearing services. If a condition or illness is diagnosed during an EPSDT screen, then any necessary services must be provided to the child, regardless of whether the services are covered under the state Medicaid plan.

States that chose to use an S-SCHIP program were granted more flexibility under title XXI, but the legislation provided specific options for benefit packages from which states could choose. States had four options for structuring their S-SCHIP benefit package:

- ***Benchmark Coverage***. The first option allowed states to offer benefits that are equal to the benefits offered in one of three types of benchmark plans: (1) the standard Blue Cross/Blue Shield preferred provider option (PPO) offered under the Federal Employees' Health Benefits Program (FEHBP); (2) the state employee plan; or (3) the HMO with the largest commercial, non-Medicaid enrollment in the state.
- ***Benchmark-Equivalent Coverage***. The second option allowed states to offer a benefit package that has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages. The coverage must include certain basic benefits: inpatient and outpatient hospital services, physician services, laboratory and X-ray services, and well-baby and well-child care, including age-appropriate immunizations. In addition, there must be substantial actuarial value (at least 75 percent) for specific types of services, provided those categories are included in the state's benchmark plan (coverage of prescription drugs, mental health services, vision services, and hearing services).
- ***Existing Comprehensive State-Based Coverage***. The third option allowed New York, Florida, and Pennsylvania to incorporate their existing children's health program benefits into SCHIP.
- ***Secretary-Approved Coverage.*** The fourth option allowed the Secretary to approve other health benefit plans that a state proposes.

The title XXI statute also set limits on cost sharing under SCHIP. For children with family incomes greater than 150 percent of poverty, cost sharing may be required on a sliding scale related to income, as long as total annual cost sharing for all children in the family does not exceed 5 percent of the family's income. For children with family incomes at or below 150 percent of poverty, enrollment fees, premiums, or other similar charges may not be required if they exceed the maximum monthly charges allowed under Medicaid.

States with S-SCHIP programs must also adhere to several other provisions related to cost sharing. First, states may only vary cost sharing based on family income in a manner that does not favor children with higher income over those with lower income. Second, preventive services—well-baby and well-child care, age-appropriate immunizations, and routine preventive and diagnostic dental services (if the state covers dental services)—may not be subject to cost sharing. Third, cost sharing may not be imposed on American Indian and Alaska Native children.

Title XXI (section 2108(b)(1)(B)(iii)) mandated that the state evaluations assess the benefits covered by their SCHIP programs and the cost sharing associated with those programs. This chapter contains three sections. Section A summarizes state-reported cost-sharing requirements implemented under SCHIP programs. Section B examines the scope of benefits covered by SCHIP programs as reported by the states. Section C reviews how states reported monitoring compliance with the 5 percent cap on family cost sharing.

SCHIP benefit packages varied substantially across states. As a result, simple descriptions of covered benefits mask the level of variability and complexity across states, and even among the program models within states. Therefore, Appendix C supplements the information on benefit limits and cost-sharing provisions for selected services. The appendix also includes a simulation of families' out-of-pocket expenditures under SCHIP, based on three hypothetical scenarios.

A. STATE COST-SHARING STRUCTURES

Cost sharing allows states—and the health plans or physicians with which they contract—to control utilization and to share the cost of services with enrollees. It also enables S-SCHIP coverage to more closely resemble that offered by private health insurance coverage. The potential benefits of using cost sharing are twofold. Families with uninsured children may find the program more attractive to the extent that cost sharing reduces the stigma associated with accepting a "free handout" from a public insurance program. At the same time, cost sharing narrows the cost differential between public and private insurance, making public insurance less attractive to families who otherwise can afford private coverage.

Twenty-nine states reported that they had cost-sharing requirements for their SCHIP enrollees. Twenty-one states required premiums from all or some enrollees, 22 had copayments or coinsurance at the point of service, and 3 charged enrollment fees on an annual or monthly basis (Table IV.1). No states explicitly indicated using deductibles in their SCHIP programs, although some plans participating in Massachusetts' premium assistance component may use deductibles.

Thirteen of the 18 combination programs had cost sharing (although, typically, only in their S-SCHIP component), as did 11 of the 16 states with only S-SCHIP programs. Five of the 17 states with only M-SCHIP programs required cost sharing. Cost sharing was more common among S-SCHIP programs than among M-SCHIP programs for several reasons. First, M-SCHIP programs must comply with Medicaid cost-sharing rules (although some states with M-SCHIP programs have been allowed to impose higher cost-sharing through Medicaid section 1115 demonstration projects). Second, some states included cost sharing because they modeled their S-SCHIP programs on private health insurance coverage available in the state. Third, S-SCHIP programs typically extend eligibility to higher-income populations than M-SCHIP programs and cost sharing has been implemented as a strategy to avoid substitution of public for private coverage.

Premiums, in particular, were far more common in S-SCHIP programs. Twenty-one states noted that they required premium payments from all or some enrollees, including 11 of the 18 states with combination programs, 7 of the 16 states with S-SCHIP-only programs, and 3 of the 17 states with M-SCHIP-only programs. In the 11 combination states with premiums, the premiums were charged only in the S-SCHIP component.

TABLE IV.1

COST-SHARING FEATURES OF SCHIP PROGRAMS

States	Type of Program	No Cost Sharing	Cost Sharing			
			Premium[a]	Copayments	Deductibles	Enrollment Fee
TOTAL		22	21	22	1	3
Alabama	COMBO		✓	✓[b]		
Alaska[e]	M-SCHIP			✓		
Arizona[f]	S-SCHIP			✓		
Arkansas	M-SCHIP	✓				
California[g]	COMBO		✓[c]	✓[c]		
Colorado[h]	S-SCHIP		✓	✓		
Connecticut	COMBO		✓[c]	✓[c]		
Delaware	S-SCHIP		✓	✓		
District of Columbia	M-SCHIP	✓				
Florida[i]	COMBO		✓[c]	✓		
Georgia	S-SCHIP		✓			
Hawaii	M-SCHIP	✓				
Idaho	M-SCHIP	✓				
Illinois[j]	COMBO		✓[c]	✓		
Indiana	COMBO	✓				
Iowa	COMBO		✓[c]	✓		
Kansas	S-SCHIP		✓			
Kentucky	COMBO	✓				
Louisiana	M-SCHIP	✓				
Maine	COMBO		✓[c]			
Maryland	M-SCHIP	✓				
Massachusetts[k]	COMBO		✓[c]	✓	✓	
Michigan	COMBO		✓[c]			
Minnesota	M-SCHIP	✓				
Mississippi[l]	COMBO			✓		
Missouri[m]	M-SCHIP		✓	✓		
Montana[n]	S-SCHIP			✓		✓
Nebraska	M-SCHIP	✓				
Nevada	S-SCHIP		✓			
New Hampshire	COMBO		✓[c]	✓		
New Jersey[o]	COMBO		✓[c]	✓		
New Mexico[p]	M-SCHIP			✓		
New York	COMBO		✓[c]			
North Carolina[q]	S-SCHIP			✓		✓
North Dakota	COMBO	✓				
Ohio	M-SCHIP	✓				
Oklahoma	M-SCHIP	✓				
Oregon	S-SCHIP	✓				
Pennsylvania	S-SCHIP	✓				
Rhode Island[r]	M-SCHIP		✓	✓		

Table IV.1 (*Continued*)

States	Type of Program	No Cost Sharing	Cost Sharing			
			Premium[a]	Copayments	Deductibles	Enrollment Fee
South Carolina	M-SCHIP	✓				
South Dakota	COMBO	✓				
Tennessee	M-SCHIP	✓				
Texas	COMBO	✓				
Utah [a]	S-SCHIP			✓		
Vermont	S-SCHIP					✓
Virginia	S-SCHIP	✓				
Washington [b]	S-SCHIP		✓	✓		
West Virginia	S-SCHIP	✓				
Wisconsin [c]	M-SCHIP		✓	✓		
Wyoming	S-SCHIP	✓				

SOURCE: Mathematica Policy Research analysis of the title XXI State Evaluations, Sections 3.2.1, 3.3.1, and 3.3.7 of the State Evaluation Framework.

NOTE: The type of SCHIP program is as of March 31, 2001. The state evaluations generally present program characteristics as of September 30, 1999.

[a] For detailed premium information, see Table IV.2.

[b] In the Alabama S-SCHIP program, children between 100 and 150 percent of poverty have no cost sharing. For children between 151 and 200 percent of poverty there is no deductible and a $5 copay on some services in addition to a $50 per year premium with a premium maximum of $150 per family per year. In the M-SCHIP program, only 18 year olds are subject to copayments.

[c] Applies only to S-SCHIP program.

[d] Applies to both S-SCHIP and M-SCHIP program.

[e] In Alaska, only 18 year olds are subject to copayments.

[f] Arizona applies copays only to emergency room use.

[g] California's S-SCHIP program has a cap on coapys of $250 per family per year.

[h] In Colorado's S-SCHIP program, copayments vary by income. There are no copayments for families with income under 101 percent of poverty. Families between 101 and 150 percent of poverty pay a smaller copay than families between 151 and 185 percent of poverty.

[i] Florida has three S-SCHIP programs: Healthy Kids, CMS, and MediKids. Healthy Kids is the only program with copayments.

[j] In Illinois, the annual copayment maximum per family is $100. Families with children who are American Indian or Alaska Natives do not pay premiums or copays. S-SCHIP cost sharing varies based on program: KidCare Share covers children greater than 133 to 150 percent of poverty; KidCare Premium covers children between 151 and 185 percent of poverty. Copayments vary by service and income level; premiums vary by income level.

[k] Massachusetts has three S-SCHIP programs: Family Assistance Direct Coverage (FADC), Family Assistance Premium Assistance (FAPA), and CommonHealth (CH). CH has no cost sharing. FADC has no copayments, although it does have premiums. FAPA has premiums; copayments are in accordance with the individual ESI policy, subject to limitations under title XXI.

[l] In Mississippi, there are no cost-sharing requirements for families with income below 150 percent of poverty or for American Indian/Native Alaskan children. Families in the S-SCHIP program, with incomes between 150 and 175 percent of poverty have copays on certain services and pay a maximum out of pocket of $800 per calendar year. Families with incomes between 176 percent and 200 percent of poverty have higher copays on certain services and pay a maximum out of pocket of $950 per calendar year. There is no copay for preventive services.

[m] Families with incomes between 226 and 300 percent of poverty must pay a premium for the Missouri M-SCHIP program. Copayments also vary by income: families with incomes between 186 and 225 percent pay smaller copayments than families with incomes between 226 and 300 percent of poverty.

[n] Montana S-SCHIP has copayments for those with family incomes greater than 100 percent of poverty.

[o] New Jersey has three S-SCHIP programs: Plans B, C and D. Plan B offers coverage to children in families with gross incomes between 133 and 150 percent of poverty; Plan C covers children between 151 and 200 percent of poverty; and Plan D covers children between 201 and 350 percent of poverty. Only Plans C and D have any form of cost sharing.

[p] In New Mexico M-SCHIP, copayments only apply to those between 185 and 235 percent of poverty.

[q] In North Carolina, copayments only apply to those with incomes greater than 151 percent of poverty.

[r] In Rhode Island, cost sharing is only for families with income in excess of 185 percent of poverty if they elected a coinsurance rather than a premium option.

[s] In Utah, cost sharing varies by plan. Plan A applies to enrollees at or below 150 percent of poverty. Plan B enrollees have family incomes between 151 and 200 percent of poverty. Plan B has higher copayments than Plan A (although Plan A cost sharing applies only to those between 101 and 150 percent of poverty).

[t] Washington has no cost sharing for American Indians/Native Alaskans. Annual maximum out-of-pocket costs are $300 for one child, $600 for two children, and $900 for three or more children.

[u] Wisconsin copayments are only for non-pregnant adults in Medicaid FFS.

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Table IV.2 provides additional detail on the premium structure as reported by the 21 states with premiums. Among the three M-SCHIP programs charging premiums, Missouri charged premiums to families between 226 and 300 percent of poverty, while Wisconsin began premiums at 100 percent of poverty. Rhode Island allowed M-SCHIP enrollees between 185 and 250 percent of poverty to select either a premium or coinsurance option.

Only 3 of the 21 states charging premiums (Georgia, Michigan, and Washington) reported that they did not vary the premium amount by family income level. In these three states, the premium amounts were nominal, ranging from $5 per family per month in Michigan to $10 per child per month in Washington (capped at $30 per family per month). The other 18 states increased premiums as family income rose, often waiving the premium for families at the low end of the income threshold. Only six states, for example, charged premiums for families between 100 and 150 percent of poverty. Sixteen states charged premiums for families between 150 and 200 percent of poverty, and 2 states set the threshold where they began to charge premiums above 200 percent of poverty (235 percent in Connecticut and 226 percent in Missouri).

S-SCHIP premiums appeared to be structured similarly to those in commercial insurance, calculated on a per-family or per-child basis. Most states that used a per-child premium capped the premium at two children, after which families paid a flat monthly amount. Two states (Alabama and Georgia) indicated that they capped the amount paid annually by an individual family. Premium amounts varied from $4 per month per child to $120 per month per family,

TABLE IV.2

PREMIUM STRUCTURES OF SCHIP PROGRAMS

State	Program Type	Target Population (as a % of FPL)	Premium Amount	Who May Pay the Premium: Family	Absent parent	Employer	Private Donation or Sponsor	No Restrictions
Alabama	S-SCHIP	100-150	No premium					
		151-200	$50 per year per member ($60 per year if not paid in one payment); $150 per year family maximum	✓			✓	
	M-SCHIP		No premium					
California	S-SCHIP (Healthy Families)	100-150	$4-$7 per child per month; $14 per month family maximum	✓	✓		✓	
		151-250	$6-$9 per child per month; $27 per month family maximum	✓	✓		✓	
	M-SCHIP		No premium					
Colorado	S-SCHIP	<101	Premium is waived					
		101-150	$9 for single child; $15 for two or more children	✓	✓	✓	✓	
		151-170	$15 for single child; $25 for two or more children	✓	✓	✓	✓	
		171-185	$20 for single child; $30 for two or more children	✓	✓	✓	✓	
Connecticut	S-SCHIP (Husky B)	185-234	No premium					
		235-300	$30 per child per month; $50 for 2 or more children per month	✓	✓	✓	✓[a]	✓
	M-SCHIP		No premium					
Delaware	S-SCHIP	101-133	$10 per family per month	✓	✓	✓	✓	✓
		134-166	$15 per family per month	✓	✓	✓	✓	✓
		167-200	$25 per family per month	✓	✓	✓	✓	✓
Florida	S-SCHIP (HealthyKids)	<200	$15 per month per family	✓[b]	✓			
	S-SCHIP (MediKids and CMS programs)	<200	$15 per month per family, except if another child in family enrolled in a SCHIP program for which a premium was paid	✓[b]	✓			
	M-SCHIP		No premium					
Georgia	S-SCHIP		Ages 0-5 pay no premium	✓	✓	✓	✓	
			Ages 6+ pay a $7.50 monthly premium for one child; $15 monthly premium for two or more children; $180 per year family maximum	✓	✓	✓	✓	

TABLE IV.2 *(continued)*

State	Program Type	Target Population (as a % of FPL)	Premium Amount	Who May Pay the Premium				
				Family	Absent parent	Employer	Private Donation or Sponsor	No Restrictions
Illinois	S-SCHIP (KidCare Share)	>133 - 150	None					
	S-SCHIP (KidCare Premium)	151-185	$15 for one child; $25 for two children; and $30 for three or more children	✓	✓	✓	✓	✓
	M-SCHIP		No premium					
Iowa	S-SCHIP	133-149	No premium					
		150-185	$10 per child per month; $20 per month family maximum	✓	✓	✓	✓	✓
	M-SCHIP		No premium					
Kansas	S-SCHIP	100-150	No premium					
		151-175	$10 per family per month	✓	✓	✓	✓	✓
		176-200	$15 per family per month	✓	✓	✓	✓	✓
Maine	S-SCHIP	150.1 - 160	$5 for one child; $10 for two or more children	✓	✓	✓	✓	✓
		160.1- 170	$10 for one child; $20 for two or more children	✓	✓	✓	✓	✓
		170.1- 200	$15 for one child; $30 for two or more children	✓	✓	✓	✓	✓
	M-SCHIP		No premium					
Massachusetts	S-SCHIP (Direct Coverage)	150-200	$10 per child per month; $30 per month family maximum	✓				
	S-SCHIP (Premium Assistance)	150-200	$10 per child per month; $30 per month family maximum	✓		✓		
	S-SCHIP (CommonHealth)	<200	No cost sharing for disabled children					
	M-SCHIP		No premium					
Michigan	S-SCHIP		$5 per family per month	✓	✓	✓	✓	✓
	M-SCHIP		No premium					
Missouri	M-SCHIP	100-225	No premium					
		226-300	$68 per family per month	✓	✓			
Nevada	S-SCHIP	< 100	No premium					
		100-150	$10 per quarter per family[c]	✓	✓			
		151-175	$25 per quarter per family	✓	✓			
		176-200	$50 per quarter per family	✓	✓			

TABLE IV.2 *(continued)*

				Who May Pay the Premium				
State	Program Type	Target Population (as a % of FPL)	Premium Amount	Family	Absent parent	Employer	Private Donation or Sponsor	No Restrictions
New Hampshire	S-SCHIP	185-250	$20 per child per month; $100 per month family maximum	✓	✓	✓	✓	✓
		251-300	$40 per child per month; $100 per month family maximum	✓	✓	✓	✓	✓
	M-SCHIP		No premium					
New Jersey	S-SCHIP (KidCare B)	133-150	No premium					
	S-SCHIP (KidCare C)	151-200	$15 per family per month	✓	✓	✓	✓	✓
	S-SCHIP (KidCare D)	201-250	$30 per family per month	✓	✓	✓	✓	✓
		251-300	$60 per family per month	✓	✓	✓	✓	✓
		301-350	$100 per family per month	✓	✓	✓	✓	✓
	M-SCHIP (KidCare A)		No premium					
New York	S-SCHIP	100-133	No premium					
		134-185	$9 per month per child; $27 per month family maximum	✓	✓			
		186-192	$15 per month per child; $54 per month family maximum	✓	✓			
	M-SCHIP		No premium					
Rhode Island	M-SCHIP	100-185	No premium					
		>185-250	Families can select a premium or copayment option; premiums range from $1.57 - $11.94 per member per month	✓	✓	✓	✓	✓
Washington	S-SCHIP		$10 per child per month; $30 maximum per month per family	✓	✓	✓	✓	✓
Wisconsin	M-SCHIP	< 100	No premium					
		100-150	$30-90 per month based on family size	✓	✓	✓	✓	✓
		151-185	$30-120 per month based on family size	✓	✓	✓	✓	✓

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations, Sections 3.3.1 and 3.3.2 of the State Evaluation Framework.

NOTE: The type of SCHIP program is as of March 31, 2001. The state evaluations generally present program characteristics as of September 30, 1999. This table includes only states that charge premiums.

[a] In Connecticut's Husky B, the MCO must request state approval to guarantee equity and equal access by any enrollee before applying private funding.
[b] In Florida, family includes a child, grandparent, or other family member.
[c] In Nevada, some families with very low income may have the quarterly premium waived.

depending on family size and poverty level. For a family with two children between 150 and 200 percent of poverty, premiums were $20 or less per family per month in 14 states, and from about $25 to $40 per family in the remaining 7 states.

Some states reported allowing others besides family members to pay the premiums on behalf of SCHIP enrollees (Table IV.2). Thirteen states indicated that they did not restrict who paid the premium. Other states specified which groups may pay the premium, including absent parents (19 states), employers (15 states), and private donations or sponsors (15 states). Four states—Florida, Missouri, Nevada, and New York—allowed only family members or absent parents to pay the premium. Massachusetts allowed only family members to pay the premium in MassHealth Direct Coverage, whereas in the MassHealth Premium Assistance Plan, family members or employers may pay the premium.

Three states—Montana, North Carolina, and Vermont—noted that they used annual or monthly enrollment fees, with varying fee structures:

- Montana charged an annual enrollment fee of $15 for all families with incomes greater than 100 percent of the FPL.
- North Carolina charged an annual fee of $50 per child, or $100 for two or more children for all families with incomes greater than 150 percent of the FPL.
- Vermont charged a monthly enrollment fee of $20 per family.

Both Montana and North Carolina used their annual enrollment fees in conjunction with a guarantee of 12 months continuous coverage, upon payment of the fee. North Carolina noted, however, that failure to pay the enrollment fee was the most common reason for denial of an S-SCHIP application.

B. SCOPE OF BENEFITS COVERED BY SCHIP PROGRAMS

In addition to implementing varying cost-sharing policies, states have adopted benefit packages that differ substantially from state to state. In their state evaluations, states reported on benefits for 34 M-SCHIP programs and 35 S-SCHIP programs (Table IV.3).[2] All SCHIP programs covered the following services when age-appropriate to the program: inpatient services, emergency hospital services, outpatient hospital services, physician services, X-ray and laboratory services, immunizations, well-baby visits, well-child visits, inpatient and outpatient mental health treatment, vision screening, and prescription drug benefits (Figure IV.1 and Table IV.4).[3] The majority of states also reported covering hearing screenings under SCHIP.

Although S-SCHIP programs were granted more flexibility in designing their benefit package (relative to traditional Medicaid coverage), most also said they covered preventive and restorative dental services, corrective lenses, family planning, inpatient and outpatient substance abuse, durable medical equipment (DME), physical therapy, speech therapy, occupational therapy, and home health services. Coverage of dental and vision services is often not offered by private health insurance coverage; however, some states reported that they chose to augment their benefit packages because of the importance of these services to children's health and development.

Certain services, however, were less common in S-SCHIP programs than in M-SCHIP programs. These include over-the-counter medications, developmental assessments, disposable

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[2] Florida, Massachusetts, and New Jersey reported on multiple S-SCHIP plans. California and Connecticut did not report on benefits offered by their M-SCHIP programs.

[3] New Hampshire's M-SCHIP covers infants only and excludes benefits not applicable to infants, such as mental health or substance abuse services.

TABLE IV.3

SCHIP PROGRAM BENEFITS, BY STATE

Benefit	Alabama		Alaska	Arkansas	Arizona	California	Colorado	Connecticut	Delaware
	COMBO		M-SCHIP	M-SCHIP	S-SCHIP	S-SCHIP	S-SCHIP	S-SCHIP	S-SCHIP
Inpatient hospital services	○	●	○	○	●	●	●	●	●
Emergency hospital services	○	●	○	○	●	●	●	●	●
Outpatient hospital services	○	●	○	○	●	●	●	●	●
Physician services	○	●	○	○	●	●	●	●	●
Clinic services	○	●	○	○	●	●	●	●	●
Prescription drugs	○	●	○	○	●	●	●	●	●
Over-the-counter medications	○			○	●	●			●
Outpatient laboratory and radiology services	○	●	○	○	●	●	●	●	●
Prenatal care	○	●	○	○	●	●	●	●	●
Family planning services	○	●	○	○	●	●	●	●	●
Immunizations	○	●	○	○	●	●	●	●	●
Well-baby visits	○	●	○	○	●	●	●	●	●
Well-child visits	○	●	○	○	●	●	●	●	●
Developmental assessment	○	●	○	○	●	●	●	●	●
Inpatient mental health services	○	●	○	○	●	●	●	●	●
Outpatient mental health services	○	●	○	○	●	●	●	●	●
Inpatient substance abuse treatment services	○	●	○	○	●	●	●	●	●
Residential substance abuse treatment services	○	●	○		●				●
Outpatient substance abuse treatment services	○	●	○		●	●	●	●	●
Durable medical equipment	○	●	○	○	●	●	●	●	●
Disposable medical supplies	○		○	○	●			●	●
Preventive dental services	○	●	○	○	●	●		●	
Restorative dental services	○	●	○	○	●	●		●	
Hearing screening	○	●	○	○	●	●	●	●	●
Hearing aids	○	●	○	○	●	●	●		●
Vision screening	○	●	○	○	●	●	●	●	●
Corrective lenses (including eyeglasses)	○	●	○	○	●	●	●	●	●
Physical therapy	○	●	○	○	●	●	●	●	●
Speech therapy	○	●	○	○	●	●	●	●	●
Occupational therapy	○	●	○	○	●	●	●	●	●
Physical rehabilitation services	○	●	○	○	●	●		●	●
Podiatric services	○	●		○	●	●	●	●	●
Chiropractic services	○	●	○	○	●	●		●	DE1
Medical transportation	○		○	○	●	●	●	●	●
Home health services	○	●	○	○	●	●	●	●	●
Nursing facility	○	●	○	○	●	●	●	●	
ICF/MR	○		○	○					
Hospice care	○	●	○	○	●	●	●	●	●
Private duty nursing	○		○	○	●				●
Personal care services	○		○	○	●				
Habilitative services	○			○	●				●
Case management/Care coordination	○	●	○	○	●	●	●		●
Non-emergency transportation	○		○	○		●			
Interpreter services				AR1	●	●			
TOTAL	**43**	**35**	**40**	**41**	**42**	**38**	**31**	**34**	**36**

○ = M-SCHIP

● = S-SCHIP

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Table IV.3 *(continued)*

Benefit	District of Columbia		Florida					Georgia	Hawaii	Idaho
	M-SCHIP (DC1)		COMBO (FL1)					S-SCHIP	M-SCHIP	M-SCHIP
			M-SCHIP	HK	MK	CMS				
Inpatient hospital services	○		○	●	●	●		●	○	○
Emergency hospital services	○		○	●	●	●		●	○	○
Outpatient hospital services	○		○	●	●	●		●	○	○
Physician services	○		○	●	●	●		●	○	○
Clinic services	○		○	●	●	●		●	○	○
Prescription drugs	○		○	●	●	●		●	○	○
Over-the-counter medications			○		●	●	FL2	●	○	
Outpatient laboratory and radiology services	○		○	●	●	●		●	○	○
Prenatal care	○		○	●	●	●		●	○	○
Family planning services	○		○	●	●	●		●	○	○
Immunizations	○		○	●	●	●		●	○	○
Well-baby visits	○		○	●	●	●		●	○	○
Well-child visits	○		○	●	●	●		●	○	○
Developmental assessment	○		○		●	●	FL3		○	○
Inpatient mental health services	○		○	●	●	●		●	○	○
Outpatient mental health services	○		○	●	●	●		●	○	○
Inpatient substance abuse treatment services	○		○	●	●	●		●	○	
Residential substance abuse treatment services	○	DC2		●		●		●	○	
Outpatient substance abuse treatment services	○		○	●	●	●		●	○	○
Durable medical equipment	○		○	●	●	●		●	○	○
Disposable medical supplies	○		○	●	●	●		●	○	○
Preventive dental services	○		○		●	●		●	○	○
Restorative dental services	○		○		●	●		●	○	○
Hearing screening	○		○	●	●	●	FL3	●	○	○
Hearing aids	○		○	●	●	●		●	○	○
Vision screening	○		○	●	●	●	FL3	●	○	○
Corrective lenses (including eyeglasses)	○		○	●	●	●		●	○	○
Physical therapy	○		○	●	●	●		●	○	○
Speech therapy	○		○	●	●	●		●	○	○
Occupational therapy	○		○	●	●	●		●	○	○
Physical rehabilitation services	○		○	●	●	●			○	
Podiatric services	○		○	●	●	●		●	○	○
Chiropractic services			○	●	●	●			○	○
Medical transportation	○		○	●	●	●		●	○	○
Home health services	○		○	●	●	●		●	○	○
Nursing facility	○		○	●	●	●			○	○
ICF/MR	○		○		●	●			○	○
Hospice care	○		○	●	●	●		●	○	○
Private duty nursing	○		○	●	●	●			○	○
Personal care services	○		○			●	FL4		○	○
Habilitative services	○					●			○	○
Case management/Care coordination	○		○		●	●			○	○
Non-emergency transportation	○		○		●	●			○	○
Interpreter services	○		○		●	●			○	○
TOTAL	**42**		**42**	**34**	**41**	**44**		**33**	**44**	**40**

○ = M-SCHIP

● = S-SCHIP

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Table IV.3 *(continued)*

Benefit	Illinois			Indiana	Iowa			Kansas	Kentucky			Louisiana	Maine	
	COMBO (IL1)			M-SCHIP	COMBO (IA1)			S-SCHIP	COMBO (KY1)			M-SCHIP	COMBO	
Inpatient hospital services	○	●		○	○	●		●	○	●		○	○	●
Emergency hospital services	○	●		○	○	●		●	○	●		○	○	●
Outpatient hospital services	○	●		○	○	●		●	○	●		○	○	●
Physician services	○	●		○	○	●		●	○	●		○	○	●
Clinic services	○	●		○	○	●		●	○	●		○	○	●
Prescription drugs	○	●		○	○	●		●	○	●		○	○	●
Over-the-counter medications	○	●		○	○			●	○	●			○	●
Outpatient laboratory and radiology services	○	●		○	○	●		●	○	●		○	○	●
Prenatal care	○	●		○	○	●		●	○	●		○	○	●
Family planning services	○	●		○	○	●		●	○	●		○	○	●
Immunizations	○	●		○	○	●		●	○	●		○	○	●
Well-baby visits	○	●		○	○	●	IA2	●	○	●		○	○	●
Well-child visits	○	●		○	○	●	IA2	●	○	●		○	○	●
Developmental assessment	○			○	○	●		●	○	●			○	●
Inpatient mental health services	○	●		○	○	●		●	○	●		○	○	●
Outpatient mental health services	○	●		○	○	●		●	○	●		○	○	●
Inpatient substance abuse treatment services	○	●		○	○	●		●	○	●		○	○	●
Residential substance abuse treatment services	○	●		○	○			●	○	●			○	●
Outpatient substance abuse treatment services	○	●		○	○	●		●	○	●		○	○	●
Durable medical equipment	○	●		○	○	●		●	○	●		○	○	●
Disposable medical supplies	○	●		○	○	●		●	○	●		○	○	●
Preventive dental services	○	●		○	○	●		●	○	●		○	○	●
Restorative dental services	○	●		○	○	●		●	○	●		○	○	●
Hearing screening	○	●		○	○	●		●	○	●		○	○	●
Hearing aids	○	●		○	○	●		●	○	●		○	○	●
Vision screening	○	●		○	○	●		●	○	●		○	○	●
Corrective lenses (including eyeglasses)	○	●		○	○	●		●	○	●		○	○	●
Physical therapy	○	●		○	○	●		●	○	●		○	○	●
Speech therapy	○	●		○	○	●		●	○	●		○	○	●
Occupational therapy	○	●		○	○	●		●	○		KY2	○	○	●
Physical rehabilitation services	○	●		○	○	●		●	○	●		○	○	●
Podiatric services	○	●		○	○	●		●	○	●		○	○	●
Chiropractic services	○	●		○	○	●		●				○	○	●
Medical transportation	○	●		○	○	●	IA3	●	○	●		○	○	●
Home health services	○	●		○	○	●		●	○	●		○	○	●
Nursing facility	○	●		○	○	●	IA4		○	●		○	○	●
ICF/MR	○	●		○	○				○	●		○	○	●
Hospice care	○	●		○	○	●		●	○	●				
Private duty nursing	○	●		○	○		IA5	●	○		KY2		○	●
Personal care services	○							●	○	●		○	○	●
Habilitative services	○							●	○	●			○	●
Case management/Care coordination	○	●	IL2	○	○	●		●	○	●		○	○	●
Non-emergency transportation	○	●		○	○			●	○			○	○	●
Interpreter services				○	○		IA6	●	○	●			○	●
TOTAL	**43**	**40**		**42**	**42**	**36**		**42**	**43**	**40**		**37**	**43**	**43**

○ = M-SCHIP
● = S-SCHIP

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Table IV.3 *(continued)*

Benefit	Maryland	Massachusetts					Michigan		Minnesota	Mississippi		Missouri
	M-SCHIP	COMBO (MA1)					COMBO		M-SCHIP	COMBO		M-SCHIP
		M-SCHIP	FADC	FAPA	CH							
Inpatient hospital services	○	○	●	●	●		○	●	○	○	●	○
Emergency hospital services	○	○	●	●	●		○	●	○	○	●	○
Outpatient hospital services	○	○	●	●	●		○	●	○	○	●	○
Physician services	○	○	●	●	●		○	●	○	○	●	○
Clinic services	○	○	●	●	●		○	●	○	○	●	○
Prescription drugs	○	○	●	●	●		○	●	○	○	●	○
Over-the-counter medications	○	○	●	●	●	MA2	○		○			○
Outpatient laboratory and radiology services	○	○	●	●	●		○	●	○	○	●	○
Prenatal care	○	○	●	●	●		○	●	○	○	●	○
Family planning services	○	○	●	●	●		○	●	○	○	●	○
Immunizations	○	○	●	●	●	MA3	○	●	○	○	●	○
Well-baby visits	○	○	●	●	●	MA3	○	●	○	○	●	○
Well-child visits	○	○	●	●	●	MA3	○	●	○	○	●	○
Developmental assessment	○	○	●	●	●		○	●	○	○	●	○
Inpatient mental health services	○	○	●	●	●		○	●	○	○	●	○
Outpatient mental health services	○	○	●	●	●		○	●	○	○	●	○
Inpatient substance abuse treatment services	○	○	●	●	●		○	●	○	○	●	○
Residential substance abuse treatment services	○	○					○	●	○	○	●	○
Outpatient substance abuse treatment services	○	○	●	●	●		○	●	○	○	●	○
Durable medical equipment	○	○	●	●	●		○	●	○	○	●	○
Disposable medical supplies	○	○	●	●	●		○	●	○	○	●	○
Preventive dental services	○	○	●	●	●		○	●	○	○	●	○
Restorative dental services	○		●	●	●		○	●	○	○	●	○
Hearing screening	○				●		○	●	○	○	●	○
Hearing aids	○	○	●	●	●		○	●	○	○	●	○
Vision screening	○	○	●	●	●		○	●	○	○	●	○
Corrective lenses (including eyeglasses)	○	○	●	●	●		○	●	○	○	●	○
Physical therapy	○	○	●	●	●		○	●	○	○	●	○
Speech therapy	○	○	●	●	●		○	●	○	○	●	○
Occupational therapy	○	○	●	●	●		○	●	○	○	●	○
Physical rehabilitation services	○	○	●	●	●		○		○	○	●	○
Podiatric services	○	○	●	●	●		○	●	○	○	●	○
Chiropractic services	○	○	●	●	●		○	●	○	○	●	
Medical transportation	○	○	●	●	●		○	●	○	○		○
Home health services	○	○	●	●	●		○	●	○	○	●	○
Nursing facility	○	○					○	●	○	○	●	
ICF/MR	○	○					○	●	○	○	●	
Hospice care	○	○	●	●	●		○	●	○	○	●	○
Private duty nursing	○	○			●		○	●	○			○
Personal care services	○	○			●		○		○			○
Habilitative services	○								○			○
Case management/Care coordination	○	○					○	●	○	○		○
Non-emergency transportation	○	○			●		○		○			
Interpreter services	○						○	●	○	○	●	○
TOTAL	**44**	**40**	**34**	**34**	**38**		**43**	**39**	**44**	**39**	**37**	**40**

○ = M-SCHIP

● = S-SCHIP

Table IV.3 *(continued)*

Benefit	Montana	Nebraska		Nevada	New Hampshire		New Jersey			New Mexico	
	S-SCHIP	M-SCHIP		S-SCHIP	COMBO (NH1)		COMBO (NJ1)			M-SCHIP (NM1)	
							A	B&C	D		
Inpatient hospital services	●	○		●	○	●	○	●	●	○	
Emergency hospital services	●	○		●	○	●	○	●	●	○	
Outpatient hospital services	●	○		●	○	●	○	●	●	○	
Physician services	●	○		●	○	●	○	●	●	○	
Clinic services	●	○	NE1	●	○	●	○	●	●	○	
Prescription drugs	●	○		●	○	●	○	●	●	○	
Over-the-counter medications		○		●	○		○			○	
Outpatient laboratory and radiology services	●	○		●	○	●	○	●	●	○	
Prenatal care	●	○		●		●	○	●	●	○	
Family planning services	●	○		●		●	○	●	●	○	
Immunizations	●	○		●	○	●	○	●	●	○	
Well-baby visits	●	○		●	○	●	○	●	●	○	
Well-child visits	●	○		●		●	○	●	●	○	
Developmental assessment		○		●	○	●	○			○	
Inpatient mental health services	●	○		●		●	○	●	●	○	
Outpatient mental health services	●	○		●		●	○	●	●	○	
Inpatient substance abuse treatment services	●	○		●		●	○	●	●	○	
Residential substance abuse treatment services	●	○		●						○	
Outpatient substance abuse treatment services	●	○		●		●	○	●	●	○	
Durable medical equipment		○		●		●	○	●		○	
Disposable medical supplies		○		●	○	●	○	●		○	
Preventive dental services		○		●		●	○	●	●	○	
Restorative dental services		○		●		●	○	●		○	
Hearing screening	●	○		●	○	●	○	●	NJ2	○	
Hearing aids		○		●	○	●	○	●		○	
Vision screening	●	○		●	○	●	○	●	●	○	
Corrective lenses (including eyeglasses)		○		●		●	○	●	●	○	
Physical therapy		○		●	○	●	○	●	●	○	
Speech therapy		○		●	○	●	○	●	●	○	
Occupational therapy		○		●	○	●	○	●	●	○	
Physical rehabilitation services		○		●	○	●		●		○	
Podiatric services		○		●	○	●	○	●	●	○	
Chiropractic services		○		●		●	○	●			
Medical transportation		○		●	○	●	○	●	●	○	
Home health services		○		●	○	●	○	●	●	○	
Nursing facility		○		●		●	○		●	○	NM1
ICF/MR		○		●	○		○			○	NM2
Hospice care				●			○	●	●	○	
Private duty nursing		○		●	○		○	●		○	
Personal care services		○		●	○		○			○	
Habilitative services		○		●							
Case management/Care coordination		○		●	○	●	○	●		○	
Non-emergency transportation		○		●	○		○	●		○	
Interpreter services		○		●	○						
TOTAL	**19**	**43**		**44**	**28**	**35**	**40**	**36**	**27**	**41**	

○ = M-SCHIP

● = S-SCHIP

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Table IV.3 *(continued)*

Benefit	New York		North Carolina	North Dakota	Ohio	Oklahoma	Oregon	Pennsylvania	Rhode Island
	COMBO (NY1)		S-SCHIP	M-SCHIP	M-SCHIP	M-SCHIP	S-SCHIP	S-SCHIP	M-SCHIP
Inpatient hospital services	○	●	●	○	○	○	●	●	○
Emergency hospital services	○	●	●	○	○	○	●	●	○
Outpatient hospital services	○	●	●	○	○	○	●	●	○
Physician services	○	●	●	○	○	○	●	●	○
Clinic services	○	●	●	○	○	○	●		○
Prescription drugs	○	●	●	○	○	○	●	●	○
Over-the-counter medications	○	●		○	○	○	●		○
Outpatient laboratory and radiology services	○	●	●	○	○	○	●	●	○
Prenatal care	○	●		○	○	○	●		○
Family planning services	○	●	●	○	○	○	●		○
Immunizations	○	●	●	○	○	○	●	●	○
Well-baby visits	○	●	●	○	○	○	●	●	○
Well-child visits	○	●	●	○	○	○	●	●	○
Developmental assessment	○	●		○	○	○	●	●	○
Inpatient mental health services	○	●	●	○	○	○	●	●	○
Outpatient mental health services	○	●	●	○	○	○	●	●	○
Inpatient substance abuse treatment services	○	●	●	○	○	○	●	●	○
Residential substance abuse treatment services	○	●	●	○	○	○	●	●	○
Outpatient substance abuse treatment services	○	●	●	○	○	○	●	●	○
Durable medical equipment	○	●	●	○	○	○	●	●	○
Disposable medical supplies	○	●	●	○	○	○	●	●	○
Preventive dental services	○	●	●	○	○	○	●	●	○
Restorative dental services	○	●	●	○	○	○	●	●	○
Hearing screening	○	●	●	○	○	○	●	●	○
Hearing aids	○	●	●	○	○	○	●	●	○
Vision screening	○	●	●	○	○	○	●	●	○
Corrective lenses (including eyeglasses)	○	●	●	○	○	○	●	●	○
Physical therapy	○	●	●	○	○	○	●	●	○
Speech therapy	○	●	●	○	○	○	●	●	○
Occupational therapy	○	●	●	○	○	○	●	●	○
Physical rehabilitation services	○	●	●	○	○	○	●	●	○
Podiatric services	○	●	●	○	○	○	●		○
Chiropractic services	○		●	○	○	○	●		○
Medical transportation	○		●	○	○	○	●	●	○
Home health services	○	●	●	○	○	○	●	●	○
Nursing facility	○		●	○	○	○	●		○
ICF/MR	○		●	○	○		●		○
Hospice care	○		●	○	○	○	●		○
Private duty nursing	○		●	○	○	○	●		○
Personal care services	○	●			○		●		○
Habilitative services					○	○	●		
Case management/Care coordination	○		●	○	○	○	●		○
Non-emergency transportation	○			○	○	○	●		○
Interpreter services						○	●		○
TOTAL	**42**	**34**	**37**	**41**	**43**	**42**	**44**	**29**	**43**

○ = M-SCHIP

● = S-SCHIP

Table IV.3 *(continued)*

Benefit	South Carolina	South Dakota	Tennessee	Texas	Utah		Vermont
	M-SCHIP	M-SCHIP	M-SCHIP	M-SCHIP	S-SCHIP		S-SCHIP
Inpatient hospital services	○	○	○	○	●		●
Emergency hospital services	○	○	○	○	●		●
Outpatient hospital services	○	○	○	○	●		●
Physician services	○	○	○	○	●		●
Clinic services	○	○	○	○			●
Prescription drugs	○	○	○	○	●		●
Over-the-counter medications			○				●
Outpatient laboratory and radiology services	○	○	○	○	●		●
Prenatal care	○	○	○	○	●		●
Family planning services	○	○	○	○	●		●
Immunizations	○	○	○	○	●		●
Well-baby visits	○	○	○	○	●		●
Well-child visits	○	○	○	○	●		●
Developmental assessment	○	○	○	○			●
Inpatient mental health services	○	○	○	○	●		●
Outpatient mental health services	○	○	○	○	●		●
Inpatient substance abuse treatment services	○	○	○		●		●
Residential substance abuse treatment services	○	○	○		●		●
Outpatient substance abuse treatment services	○	○	○	○	●		●
Durable medical equipment	○	○	○	○	●		●
Disposable medical supplies	○	○	○	○		UT1	●
Preventive dental services	○	○	○	○	●		●
Restorative dental services	○	○	○	○	●		●
Hearing screening	○	○	○	○	●		●
Hearing aids	○	○	○	○	●		●
Vision screening	○	○	○	○	●		●
Corrective lenses (including eyeglasses)	○	○	○	○			●
Physical therapy	○	○	○	○	●		●
Speech therapy	○	○	○	○	●		●
Occupational therapy	○	○	○	○	●		●
Physical renabilitation services	○	○	○	○			●
Podiatric services	○	○	○	○	●		●
Chiropractic services	○	○	○	○	●		●
Medical transportation	○	○	○	○	●		●
Home health services	○	○	○	○	●		●
Nursing facility	○	○	○				●
ICF/MR	○	○	○	○			●
Hospice care	○		○	○	●		●
Private duty nursing	○	○	○	○			●
Personal care services	○	○	○	○			●
Habilitative services		○	○				
Case management/Care coordination	○	○	○	○	●		
Non-emergency transportation	○	○	○	○			●
Interpreter services			○				●
TOTAL	**41**	**41**	**44**	**38**	**31**		**42**

○ = M-SCHIP
● = S-SCHIP

Table IV.3 *(continued)*

	Virginia		Washington	West Virginia		Wisconsin	Wyoming
Benefit	S-SCHIP		S-SCHIP	S-SCHIP (WV1)		M-SCHIP	S-SCHIP
Inpatient hospital services	●		●	○	●	○	●
Emergency hospital services	●		●	○	●	○	●
Outpatient hospital services	●		●	○	●	○	●
Physician services	●		●	○	●	○	●
Clinic services	●		●	○	●	○	●
Prescription drugs	●		●	○	●	○	●
Over-the-counter medications	●		●	○		○	●
Outpatient laboratory and radiology services	●		●	○	●	○	●
Prenatal care	●		●	○	●	○	●
Family planning services	●		●	○	●	○	●
Immunizations	●	VA1	●	○	●	○	●
Well-baby visits	●	VA1	●	○	●	○	●
Well-child visits	●	VA1	●	○	●	○	●
Developmental assessment	●	VA1	●	○		○	●
Inpatient mental health services	●		●	○	●	○	●
Outpatient mental health services	●		●	○	●	○	●
Inpatient substance abuse treatment services	●		●	○	●	○	
Residential substance abuse treatment services	●		●	○	●	○	
Outpatient substance abuse treatment services	●		●	○	●	○	●
Durable medical equipment	●		●	○	●	○	●
Disposable medical supplies	●		●	○	●	○	●
Preventive dental services	●		●	○	●	○	●
Restorative dental services	●		●	○	●	○	●
Hearing screening	●		●	○	●	○	●
Hearing aids	●		●	○	●	○	●
Vision screening	●		●	○	●	○	●
Corrective lenses (including eyeglasses)	●		●	○	●	○	●
Physical therapy	●		●	○	●	○	●
Speech therapy	●		●	○	●	○	
Occupational therapy	●		●	○	●	○	
Physical rehabilitation services	●		●	○	●	○	●
Podiatric services	●		●	○		○	
Chiropractic services			●	○	●	○	
Medical transportation	●		●	○	●	○	●
Home health services	●		●	○	●	○	●
Nursing facility	●		●	○	●	○	
ICF/MR	●	VA2	●	○		○	
Hospice care	●		●	○	●	○	●
Private duty nursing			●	○		○	
Personal care services	●	VA2	●	○		○	
Habilitative services	●	VA3	●	○		○	
Case management/Care coordination	●		●	○	●	○	●
Non-emergency transportation	●		●	○		○	●
Interpreter services			●			○	●
TOTAL	**41**		**44**	**43**	**35**	**44**	**33**

○ = M-SCHIP

● = S-SCHIP

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Table IV.3 *(continued)*

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations, Section 3.2.1 of the State Evaluation Framework.

NOTE: The program type reflects the type of program in existence at the time of the State Evaluations. California and Connecticut, both Combination states, only reported on the benefits in S-SCHIP programs.

AR1	Arkansas will pay for a case manager to arrange for interpreter services, but Medicaid does not cover the interpreter services.
CA1	California reported benefits for its S-SCHIP program, not its M-SCHIP program.
CT1	Connecticut reported benefits for its S-SCHIP program, not its M-SCHIP program.
DE1	In Delaware, chiropractic services are provided if they are covered by the MCO.
DC1	The District of Columbia offers a special program for children with special health care needs who are SSI recipients only; all other services available under the Medicaid State Plan for the District of Columbia.
DC2	Residential Treatment is for those children in FFS only.
FL1	Florida is a combination state with and M-SCHIP program an three S-SCHIP programs: Healthy Kids, MediKids, and Children's Medical Services (CMS). The Behavioral Health Care Specialty Network Services (BHSCN) is a carveout available to CMS
FL2	Florida's M-SCHIP and MediKids programs provide limited coverage for over-the-counter medications.
FL3	Florida's M-SCHIP and MediKids programs offers vision screenings, hearing screenings, and developmental assessments as a part of EPSDT, not as separate services.
FL4	Florida's M-SCHIP program offers personal care services only through waiver programs.
IL1	Illinois offers two S-SCHIP programs: KidCare Share and KidCare Premium. The benefits for these programs are the same, although the cost sharing varies.
IL2	Illinois covers case management only.
IA1	Iowa is a Combination state that offers S-SCHIP services under the Wellmark Plans (Wellmark Classic Blue (Indemnity) and Wellmark Unity Choice (HMO)) and the Iowa Health Solutions Health Plan (HMO).
IA2	In the Iowa M-SCHIP program, well-baby and well-child visits are part of EPSDT.
IA3	Under the Iowa S-SCHIP plan, the allowable medical transportation services are air or ground ambulance services.
IA4	For S-SCHIP enrollees, the Iowa Solutions Plan covers nursing facility services; the Wellmark Plans do not cover this service.
IA5	Under the Iowa S-SCHIP plan, only inpatient private duty nursing is covered.
IA6	Interpreter services are covered in the Iowa M-SCHIP program only when they are included as a cost in Federally Qualified Health Centers (FQHCs).
KY1	The Kentucky S-SCHIP program is a Medicaid lock-alike; the only difference between the programs is that non-emergency transportation and EPSDT special services are not covered.
KY2	Because the Kentucky S-SCHIP program does not cover EPSDT Special Services, this benefit is not covered in the S-SCHIP program
MA1	Massachusetts is a Combination state with four SCHIP programs. MassHealth Standard is the M-SCHIP program. There are three S-SCHIP programs: Family Assistance Direct Coverage (FADC), Family Assistance Premium Assistance (FAPA) and CommonHealth
MA2	In FAPA, the premium assistance plan, coverage for over-the-counter medication is dependent on the ESI plan.
MA3	In FAPA, the premium assistance plan, coverage for preventive services is provided by MassHealth as a wrap-around benefit.
NE1	In Nebraska, allowable clinics are Rural Health Clinics and Federally Qualified Health Centers (FQHC).
NH1	New Hampshire's M-SCHIP program is for infants only.
NJ1	New Jersey is a Combination state with four plans: Plan A (M-SCHIP) and Plans B, C and D (S-SCHIP).
NJ2	In New Jersey's Plan D, hearing screenings are only covered as part of an MD visit.
NM1	The nursing facilities benefits offered in New Mexico's managed care package are for interim or non-permanent placement only.
NM2	New Mexico's managed care plans do not cover ICF/MR; this benefit is covered by the FFS plans.
NY1	New York did not use the framework to report M-SCHIP benefits and the benefits were crosswalked to the framework where
UT1	Disposable medical supplies are not covered. Needles are covered as part of the pharmacy benefit.
VA1	In the Virginia S-SCHIP program, developmental assessments, immunizations, well baby and well child visits are part of EPSDT.
VA2	Services are covered if they are not provided in an IMD.
VA3	Habilitative services are not covered under Virginia's S-SCHIP program, but some community mental health and nursing services are available.
WV1	At the time of the state evaluations, West Virginia had implemented a Combination SCHIP program.

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FIGURE IV.1

PERCENT OF SCHIP PROGRAMS OFFERING SELECTED BENEFITS, BY TYPE OF PROGRAM

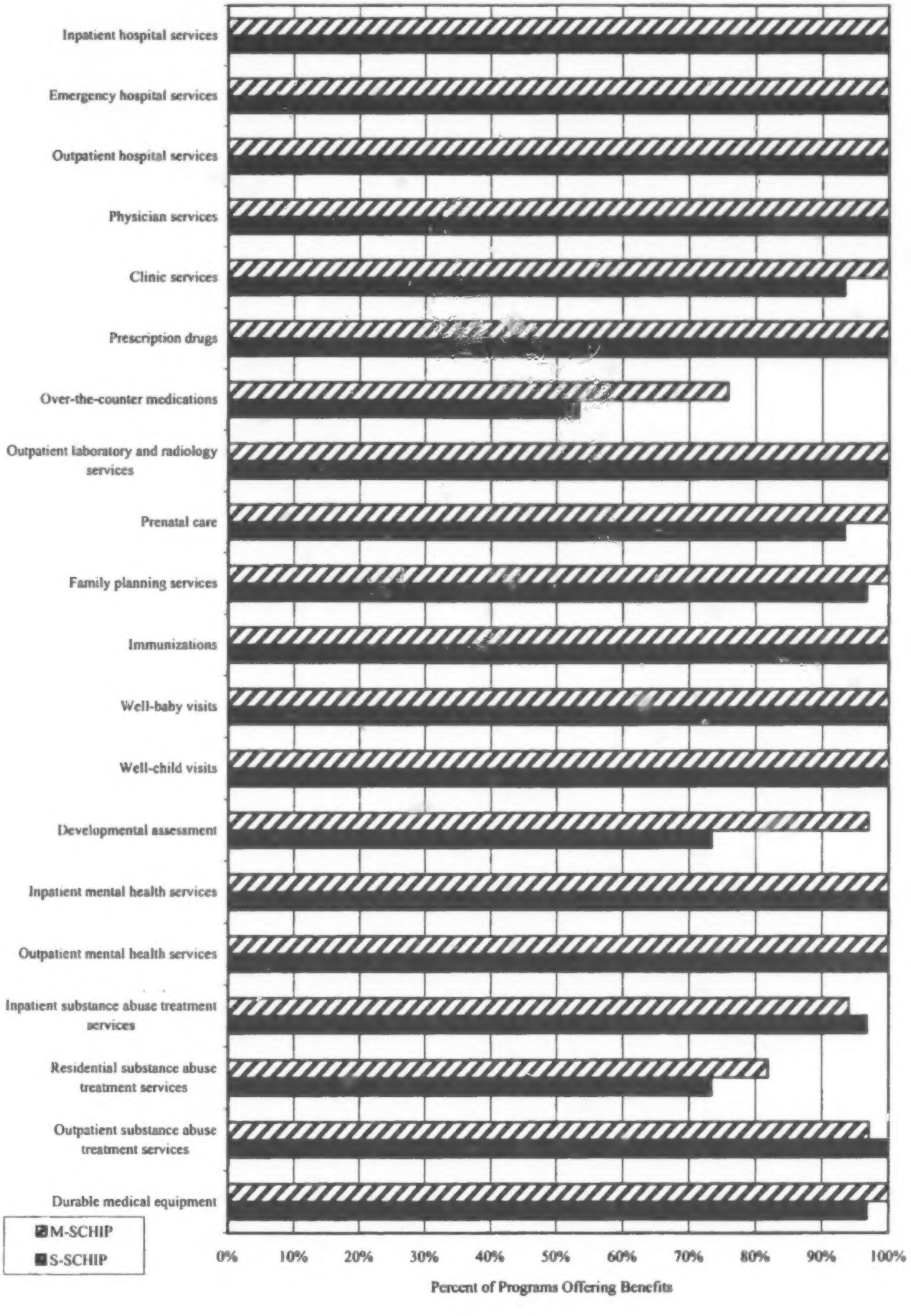

FIGURE IV.1 *(continued)*

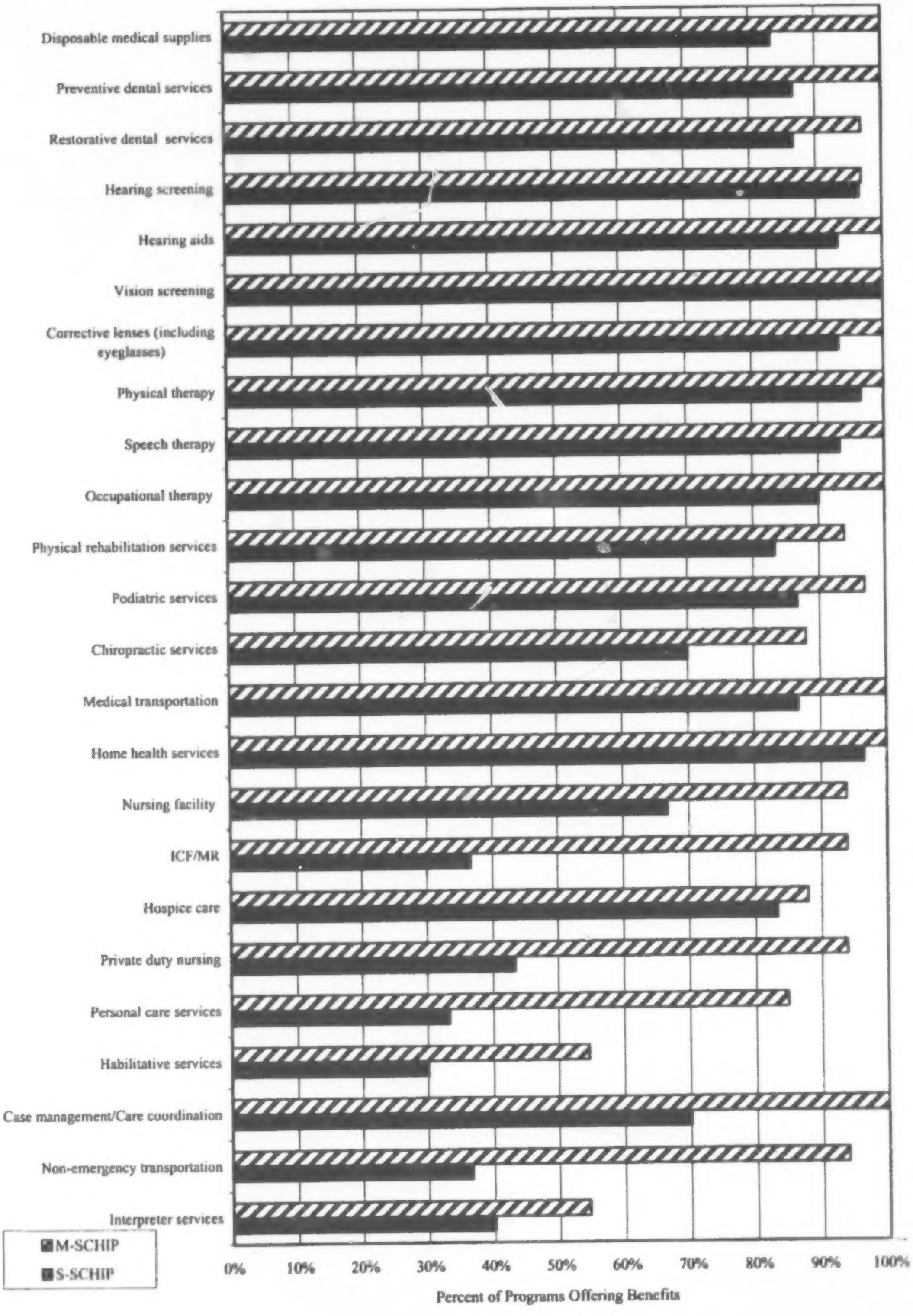

TABLE IV.4

PERCENTAGE OF SCHIP PROGRAMS OFFERING SELECTED BENEFITS, BY PROGRAM TYPE

Benefit	Percent of M-SCHIP Programs Offering Benefit	Percent of S-SCHIP Programs Offering Benefit
	N=33[a]	N=30[b]
Inpatient hospital services	100.0	100.0
Emergency hospital services	100.0	100.0
Outpatient hospital services	100.0	100.0
Physician services	100.0	100.0
Clinic services	100.0	93.3
Prescription drugs	100.0	100.0
Over-the-counter medications	75.8	53.3
Outpatient laboratory and radiology services	100.0	100.0
Prenatal care	100.0	93.3
Family planning services	100.0	96.7
Immunizations	100.0	100.0
Well-baby visits	100.0	100.0
Well-child visits	100.0	100.0
Developmental assessment	97.0	73.3
Inpatient mental health services	100.0	100.0
Outpatient mental health services	100.0	100.0
Inpatient substance abuse treatment services	93.9	96.7
Residential substance abuse treatment services	81.8	73.3
Outpatient substance abuse treatment services	97.0	100.0
Durable medical equipment	100.0	96.7
Disposable medical supplies	100.0	83.3
Preventive dental services	100.0	86.7
Restorative dental services	97.0	86.7
Hearing screening	97.0	96.7
Hearing aids	100.0	93.3
Vision screening	100.0	100.0
Corrective lenses (including eyeglasses)	100.0	93.3
Physical therapy	100.0	96.7
Speech therapy	100.0	93.3
Occupational therapy	100.0	90.0
Physical rehabilitation services	93.9	83.3
Podiatric services	97.0	86.7
Chiropractic services	87.9	70.0
Medical transportation	100.0	86.7
Home health services	100.0	96.7

Table IV.4 *(continued)*

Benefit	Percent of M-SCHIP Programs Offering Benefit	Percent of S-SCHIP Programs Offering Benefit
Nursing facility	93.9	66.7
ICF/MR	93.9	36.7
Hospice care	87.9	83.3
Private duty nursing	93.9	43.3
Personal care services	84.8	33.3
Habilitative services	54.5	30.0
Case management/Care coordination	100.0	70.0
Non-emergency transportation	93.9	36.7
Interpreter services	54.5	40.0

SOURCE: Mathematica Policy Research analysis of the title XXI State Evaluations, Section 3.2.1 of the State Evaluation Framework.

NOTE: The type of SCHIP program is as of March 31, 2001. The state evaluations generally present program characteristics as of September 30, 1999.

[a] New Hampshire's M-SCHIP program covered infants only and excluded benefits not applicable to infants, such as mental health or substance abuse services. New Hampshire M-SCHIP was excluded from this table.

[b] Florida, Massachusetts, and New Jersey reported on multiple S-SCHIP programs. Benefit data in this table include Florida Healthy Kids, MassHealth Direct Coverage, and New Jersey Plans B and C. Excluded are Florida MediKids and CMS, MassHealth Premium Assistance, and New Jersey Plan D.

medical supplies, physical rehabilitation, podiatry services, chiropractic services, medical transportation, nursing facility services, services provided in intermediate care facilities for the mentally retarded (ICF/MR), private duty nursing, and personal care services. This is primarily due to the fact that states with S-SCHIP programs had greater flexibility to design the scope of their benefits packages. Also, these services were often not offered under S-SCHIP programs, since some states opted to model their S-SCHIP programs on private health insurance coverage, which typically does not provide coverage for some of these services.

Enabling services—such as case management/care coordination, interpreter services, and non-emergency transportation—were more often covered by M-SCHIP than S-SCHIP programs (Figure IV.1 and Table IV.4). These services are generally used to reduce nonfinancial barriers and facilitate access to care. Given the focus of S-SCHIP programs on higher-income enrollees and the effort of some states to design their programs similar to private health insurance coverage, it is not surprising that S-SCHIP programs were less likely to cover such services. Two programs—one S-SCHIP and one M-SCHIP program—described the unique aspects of their enabling services:

- In Kansas, a variety of medically necessary enabling services were included in the S-SCHIP benefit package, including non-emergency medical transportation, home visits, individual need assessments, and translation of written materials into Spanish.
- Nebraska's M-SCHIP program used a network of public health nurses to conduct community outreach and individual assessment. Known as PHONE (Public Health Outreach and Nursing Education), the network covered nearly every county in the state not included in Medicaid managed care, and provided telephone access to nurses who assessed individual needs and barriers to care. The nurses helped secure medical and dental homes for Medicaid- and SCHIP-enrolled children and families; provided information and referral to additional community health services; conducted Medicaid, SCHIP, and EPSDT outreach and case management; and educated families regarding appropriate access to primary care and emergency services.

To assist children with special health care needs who are enrolled in their SCHIP programs, some states have chosen to implement care coordination or case management services within their SCHIP programs. For example:

- In Kansas, children with special health care needs received all the medically necessary services they required through the standard HealthWave benefit package. The S-SCHIP program worked with the title V Children with Special Health Care Needs program to identify special needs children and coordinated their care to the extent possible by working with the child's managed care organization. To encourage care coordination, specialty clinics were allowed to enroll a network provider to deliver services through HealthWave. Title V program staff had access to the state's automated eligibility system and could track the eligibility of any children they referred through the application process.
- Maryland's M-SCHIP program offered the Rare and Expensive Case Management (REM) program for individuals who met specific diagnostic criteria, including diseases of the nervous system, digestive and genitourinary system, cystic fibrosis, spina bifida, hemophilia, non-neonate ventilator dependency. In addition, Special Needs Coordinators in each MCO served as a resource for information and referral.
- Wisconsin's M-SCHIP program offered targeted case management to children who were developmentally disabled, under age 21 and severely emotionally disturbed, and people who were alcohol- and drug-dependent. Services included case assessment, case planning, and ongoing monitoring and service coordination. These services assisted individuals and their families to gain access to medical, social, educational, vocational, and other services.

In summary, SCHIP programs offered a core set of benefits that are important to children's health and development. Many states with S-SCHIP programs reported that they augmented their title XXI benefit package to provide additional services, such as dental and vision services, preventive care, mental health and substance abuse treatment, and durable medical equipment. This analysis, however, has focused on which benefits were offered by SCHIP programs. To the extent that states imposed limits on the number of services covered or for which they charged copays, the effective level of coverage may be different across states. Appendix C describes the many nuances in the benefit limits and the cost-sharing requirements for a wide range of services.

C. STATE MONITORING OF FAMILY COST SHARING

We turn now to a discussion of how states reported that they monitored enrollees' cost sharing to ensure compliance with the title XXI requirement that out-of-pocket expenditures for covered health services not exceed the 5 percent cap. Table IV.5 summarizes states' practices in monitoring aggregate cost sharing so that family cost sharing does not exceed the 5 percent cap.

The "shoebox method," reported by 13 states, was the most common approach. This approach requires families to save records that document cumulative levels of cost sharing. When the family reaches the 5 percent limit, they are instructed to notify the state or their health plan, to ensure that future cost-sharing charges are waived. Six states indicated that they require health plans to monitor aggregate cost sharing, and two states audited and reconciled cost-sharing outlays to identify families who have exceeded the cap.

Six states said they use a combination of these approaches to monitor aggregate costs. Three states—Florida, Iowa, and Utah—used the shoebox method to have enrollees track costs, but they also relied on a third party, such as the health plans in Utah and a third-party administrator in Iowa, to track costs to identify members who may be nearing the cap.

Ten states reported that they set their cost-sharing requirements to make it impossible to reach the 5 percent cap. California had a $250 limit on allowable health benefit copayments; only 26 children reached this limit during state fiscal year 1999. None reached the copayment maximum for services provided through the dental or vision benefit packages. The state set a goal of limiting out-of-pocket costs to 2 percent of annual household income. Assuming that a family reached the $250 copayment maximum for health benefits, the maximum family outlay would be 2.45 percent of household income.

TABLE IV.5

METHODS USED BY STATES TO MONITOR COST SHARING UNDER SCHIP

States	Type of Program	No Cost Sharing	Shoebox	Health Plan Administration	Audit and Reconciliation	Impossible to Reach 5% Cap
TOTAL		22	13	6	2	10
Alabama	COMBO		✓			
Alaska	M-SCHIP		✓			
Arizona	S-SCHIP		✓			
Arkansas	M-SCHIP	✓				
California	COMBO					✓
Colorado	S-SCHIP		✓			
Connecticut	COMBO			✓		
Delaware	S-SCHIP					✓
District of Columbia	M-SCHIP	✓				
Florida	COMBO		✓		✓	
Georgia	S-SCHIP					✓
Hawaii	M-SCHIP	✓				
Idaho	M-SCHIP	✓				
Illinois	COMBO		✓			
Indiana	COMBO	✓				
Iowa	COMBO			✓		
Kansas	S-SCHIP					✓
Kentucky	COMBO	✓				
Louisiana	M-SCHIP	✓				
Maine	COMBO					✓
Maryland	M-SCHIP	✓				
Massachusetts	COMBO		✓			
Michigan	COMBO					✓
Minnesota	M-SCHIP	✓				
Mississippi	COMBO			✓		
Missouri[a]	M-SCHIP		✓			
Montana	S-SCHIP			✓		
Nebraska	M-SCHIP	✓				
Nevada	S-SCHIP					✓
New Hampshire	COMBO				✓	
New Jersey	COMBO		✓			
New Mexico[a]	M-SCHIP		✓			
New York	COMBO					✓
North Carolina	S-SCHIP			✓		
North Dakota	COMBO	✓				
Ohio	M-SCHIP	✓				
Oklahoma	M-SCHIP	✓				
Oregon	S-SCHIP	✓				
Pennsylvania	S-SCHIP	✓				
Rhode Island[a]	M-SCHIP		✓			
South Carolina	M-SCHIP	✓				
South Dakota	COMBO	✓				
Tennessee	M-SCHIP	✓				
Texas	COMBO	✓				
Utah	S-SCHIP		✓	✓		
Vermont	S-SCHIP					✓
Virginia	S-SCHIP	✓				
Washington	S-SCHIP		✓			
West Virginia	S-SCHIP	✓				
Wisconsin[a]	M-SCHIP					✓
Wyoming	S-SCHIP	✓				

SOURCE: Mathematica Policy Research analysis of the title XXI State Evaluations, Sections 3.2.1, 3.3.1, and 3.3.7 of the State Evaluation Framework.

NOTE: The type of SCHIP program is as of March 31, 2001. The state evaluations generally present program characteristics as of September 30, 1999.

[a] Cost sharing is permitted under a section 1115 demonstration in these states.

Three states indicated that they tried to assist families in tracking whether their out-of-pocket costs exceeded the 5 percent cost-sharing cap.

- Massachusetts and Illinois assisted enrollees in tracking costs by offering worksheets or tracking forms so that families may easily determine when they reach the 5 percent cap.
- New Jersey performed a calculation to determine 80 percent of the 5 percent cap (based on family income), so that families were able to determine when they approached the limit.

The likelihood of reaching the 5 percent cap is relatively low because of the modest levels of cost sharing in most SCHIP programs. Only two states reported in their state evaluations that families hit the 5 percent cap. Montana indicated that one family reached the cap in the first nine months of its SCHIP pilot. In Utah, between August 1998 and March 2000, 93 enrollees reached the cap. Once an enrollee reached the cap, no further cost sharing was required for that year.

Eleven states noted that they had assessed the effects of premiums on participation or copayments on utilization: California, Colorado, Connecticut, Georgia, Maine, Michigan, Montana, Nevada, New Hampshire, New Jersey, and North Carolina.[4] In general, the findings revealed that affordability was not a factor in the decision to disenroll or not to enroll. Moreover, some families who found it hard to afford the premium enrolled despite the possible financial hardship. Three states summarized their findings, as follows:

- In California, post-enrollment surveys of enrollees discontinuing coverage through the Healthy Families Program indicated that premiums were not a factor in disenrollment.[5]

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[4] At the time of the state evaluations, several other states were in the process of evaluating the effects of cost sharing (Delaware, Iowa, Massachusetts, New Jersey, and Wisconsin).

[5] The state evaluation did not cite any quantitative results related to this survey.

- In Maine, a telephone survey was conducted in November 1999 with Cub Care participants to assess how easily they could afford paying the premiums on a regular basis. Participants responded as follows: very easy (27 percent), somewhat easy (34 percent), neither easy nor hard (12 percent), somewhat hard (20 percent), very hard (6 percent), and unknown (1 percent).
- New Hampshire interviewed prospective families and families who declined coverage. Many survey respondents cited cost as a reason they did not enroll their children in SCHIP; however, when asked how much they could afford, a majority reported an amount higher than the actual SCHIP premium. These findings suggest that "willingness to pay" was a more important factor than affordability in the decision not to enroll.

D. CONCLUSION

Given the flexibility offered to states under title XXI, it is not surprising that SCHIP benefit packages and cost-sharing requirements varied across states and between programs (S-SCHIP versus M-SCHIP) within states. All M-SCHIP programs offered enrollees the Medicaid benefit package and all S-SCHIP programs offered a core set of benefits (including hospital and physician services, preventive services, mental health services, prescription drugs, and X-ray and laboratory services). Most S-SCHIP programs also covered preventive and restorative dental services, corrective lenses, family planning, inpatient and outpatient substance abuse treatment, durable medical equipment, physical therapy, speech therapy, occupational therapy, and home health services. States reported that they chose to augment their S-SCHIP benefit packages in order to cover services that are important to children's health and development. Certain services, however, were less common in S-SCHIP programs than in M-SCHIP programs, such as over-the-counter medications, developmental assessments, rehabilitation services, private duty nursing, personal care, podiatry, and chiropractic services.

Despite wide variation in the scope of benefits—in terms of benefit limits and cost sharing—it appears that most states structured their cost sharing so that out-of-pocket expenses for covered services never exceeded the 5 percent cap (as required by title XXI). States reported, nevertheless, that they are using a variety of methods—such as the "shoebox" method, relying on third party assistance, or working directly with enrollees to track cost-sharing—to ensure that families do not pay cost sharing beyond their obligations.

V. STATES' CHOICE OF DELIVERY SYSTEMS TO SERVE SCHIP ENROLLEES

Title XXI allows states with S-SCHIP programs considerable flexibility in designing a delivery system to serve SCHIP enrollees, while states with M-SCHIP programs must use the Medicaid delivery system. States used a variety of approaches in their SCHIP programs to deliver and pay for services, including traditional fee-for-service (FFS); primary care case management (PCCM), where care is managed by a designated primary care physician; and managed care with capitated payments. While some states used only one type of delivery system, others combined approaches. In addition, some states with S-SCHIP programs elected to use their Medicaid delivery systems, while others developed a new delivery system that was separate from the one used by Medicaid. Many states also chose to carve out certain types of benefits and deliver them through a separate system. States reported that their choice of delivery system and use of carve-outs for certain benefits were based on several factors, including ease of implementation, costs, and conditions specified in state legislation.

The title XXI statute (section 2108(b)(1)(B)(vi)) required states to describe and analyze their choice of methods for providing child health assistance under their state plan. This chapter provides an overview of delivery systems used in SCHIP programs, as reported in the state evaluations and the Statistical Enrollment Data System (SEDS).[1] The chapter then discusses the role of carve-outs in financing and delivering specialty services to SCHIP enrollees and concludes with a synthesis of states' reflections on the challenges they faced in designing, implementing, and maintaining their SCHIP delivery systems.

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[1] SEDS is a web-based application through which states report their statistical data to CMS. States report SCHIP enrollment numbers according to age, gender, race, ethnicity, type of service delivery system, and family income.

A. OVERVIEW OF SCHIP DELIVERY SYSTEMS

According to the state evaluations, most states relied on more than one delivery system to serve SCHIP enrollees. Using enrollment data from SEDS, the dominant delivery system in each state is as follows: [2]

Dominant Delivery System	Number of States That Use Delivery System[3]	Number of States Where it is Dominant
Managed Care	43	20
PCCM	25	5
FFS	41	9
Mixed	40	17

Although 43 states had a managed care delivery system in place, it was the dominant system in only 20 states, and the sole system in 8 states (Table V.1). Most states reported using a managed care system in combination with a PCCM program and/or an FFS system, often due to regional variation in the availability of managed care or concerns about the adequacy of managed care capacity to serve certain populations. For example, in such states as Colorado, Nevada, Oklahoma, Oregon, and Wisconsin, children in counties with large urban populations typically

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[2] A system is considered dominant when data from the SCHIP Statistical Enrollment Data System for the fourth quarter of Federal fiscal year 2000 indicate that at least two-thirds of enrollees are enrolled in that system; otherwise, the delivery system is viewed as a "mixed" system.

[3] The number of states that use these delivery systems does not sum to 51 because many states use multiple delivery systems.

TABLE V.1

TYPE OF DELIVERY SYSTEMS USED BY SCHIP PROGRAMS, BY STATE AND PROGRAM TYPE

			Type of Delivery Systems Used		
State	Program Type	Dominant Type of Delivery System[a]	Managed Care	PCCM	Fee-For-Service
Total			43	25	41
Alabama	M-SCHIP	PCCM	-	✓	-
	S-SCHIP	FFS	-	-	✓
Alaska	M-SCHIP	FFS	-	-	✓
Arizona	S-SCHIP	Managed Care	✓	-	✓
Arkansas	M-SCHIP	FFS	-	✓	✓
California	M-SCHIP	Mixed System	✓	-	✓
	S-SCHIP	Managed Care	✓	-	✓
Colorado	S-SCHIP	Managed Care	✓	-	✓
Connecticut	M-SCHIP	Managed Care	✓	-	✓
	S-SCHIP	Managed Care	✓	-	-
Delaware	S-SCHIP	Managed Care	✓	-	-
District of Columbia	M-SCHIP	Managed Care	✓	-	✓
Florida	M-SCHIP	Mixed System	✓	✓	✓
	S-SCHIP	Managed Care	✓	✓	-
Georgia	S-SCHIP	PCCM	-	✓	-
Hawaii	M-SCHIP	Managed Care	✓	-	-
Idaho	M-SCHIP	FFS	-	✓	✓
Illinois	M-SCHIP	FFS	✓	-	✓
	S-SCHIP	FFS	✓	-	✓
Indiana	M-SCHIP	Mixed System	✓	✓	✓
	S-SCHIP	Mixed System	✓	-	✓
Iowa	M-SCHIP	Mixed System	✓	✓	✓
	S-SCHIP	Managed Care	✓	-	✓
Kansas	S-SCHIP	Managed Care	✓	-	-
Kentucky	M-SCHIP	PCCM	✓	✓	✓
	S-SCHIP	PCCM	✓	✓	✓
Louisiana	M-SCHIP	FFS	-	✓	✓
Maine	M-SCHIP	Mixed System	✓	✓	✓
	S-SCHIP	Mixed System	✓	✓	✓
Maryland	M-SCHIP	Managed Care	✓	-	✓
Massachusetts	M-SCHIP	Mixed System	✓	✓	✓
	S-SCHIP	Mixed System	✓	✓	✓
Michigan	M-SCHIP	Mixed System	✓	✓	✓
	S-SCHIP	Managed Care	✓	-	-
Minnesota	M-SCHIP	Mixed System	✓	-	✓
Mississippi	M-SCHIP	PCCM	-	✓	✓
	S-SCHIP	Managed Care	✓	-	-
Missouri	M-SCHIP	Mixed System	✓	-	✓
Montana	S-SCHIP	Managed Care	✓	-	-
Nebraska	M-SCHIP	Managed Care	✓	✓	✓
Nevada	S-SCHIP	Managed Care	✓	-	✓
New Hampshire	M-SCHIP	FFS	✓	-	✓
	S-SCHIP	Managed Care	✓	-	-
New Jersey	M-SCHIP	Managed Care	✓	-	✓
	S-SCHIP	Managed Care	✓	-	✓

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TABLE V.1 *(continued)*

State	Program Type	Dominant Type of Delivery System[a]	Type of Delivery Systems Used: Managed Care	Type of Delivery Systems Used: PCCM	Type of Delivery Systems Used: Fee-For-Service
New Mexico	M-SCHIP	Managed Care	✓	-	✓
New York	M-SCHIP	FFS	✓	✓	✓
	S-SCHIP	Managed Care	✓	✓	✓
North Carolina	S-SCHIP	FFS	-	-	✓
North Dakota	M-SCHIP	PCCM	✓	✓	✓
	S-SCHIP	NI	NI	NI	NI
Ohio	M-SCHIP	PCCM	✓	✓	✓
Oklahoma	M-SCHIP	Managed Care	✓	✓	-
Oregon	S-SCHIP	Managed Care	✓	✓	✓
Pennsylvania	S-SCHIP	Managed Care	✓	-	-
Rhode Island	M-SCHIP	Managed Care	✓	-	-
South Carolina	M-SCHIP	FFS	✓	-	✓
South Dakota	M-SCHIP	PCCM	-	✓	✓
	S-SCHIP	PCCM	-	✓	✓
Tennessee	M-SCHIP	Managed Care	✓	-	-
Texas	M-SCHIP	FFS	✓	✓	✓
	S-SCHIP	Managed Care	✓	-	-
Utah	S-SCHIP	Managed Care	✓	-	-
Vermont	S-SCHIP	Mixed System	✓	-	✓
Virginia	S-SCHIP	Mixed System	✓	✓	✓
Washington	S-SCHIP	Mixed System	✓	✓	✓
West Virginia	M-SCHIP	FFS	✓	✓	✓
	S-SCHIP	FFS	-	-	✓
Wisconsin	M-SCHIP	Managed Care	✓	-	✓
Wyoming	S-SCHIP	FFS	✓	✓	✓

SOURCE: Mathematica Policy Research analysis of the title XXI State Evaluations, and SCHIP Statistical Enrollment Data System (SEDS) data for Federal fiscal year 2000.

NOTE: The type of SCHIP program is as of March 31, 2001. The state evaluations generally present program characteristics as of September 30, 1999.

[a] The dominant delivery system is based on SEDS data from the fourth quarter of Federal fiscal year 2000. A system is considered dominant if at least two-thirds of children are enrolled in that system; otherwise the system is considered to be mixed. The types of delivery systems are based on Table 3.2.3 from the title XXI State Evaluation Framework.

PCCM = Primary Care Case Management.

FFS = Fee for Service.

NI = Not Implemented.

were covered through the managed care system, whereas those in rural counties were served by PCCM or FFS systems. Other states, such as New Mexico, served specific populations, such as American Indians, through an FFS system; all other populations were served through managed care.

PCCM was the dominant delivery system in five states, and nine states relied predominantly on FFS. The majority of these 14 states reported that their SCHIP programs served large rural populations in which managed care generally was not well established.

Seventeen states indicated that they mixed the three types of delivery models so that no one system dominated. As noted previously, the use of more than one system frequently reflected regional variations in health plan or provider availability within the state. For example, the configuration of delivery system options available to families in Maine and Washington varied considerably across counties. As a result, families in different counties had different choices. In 9 of the 17 states, one type of system was used for the M-SCHIP component and another for the S-SCHIP component. For example, in Michigan, Mississippi, and Texas, children covered through the M-SCHIP component were served by a variety of system types, while managed care was the only option available to children in the S-SCHIP component.

All M-SCHIP programs relied on the Medicaid delivery system (per the title XXI requirement that states with M-SCHIP programs follow all Medicaid rules); however, 16 of the 34 S-SCHIP programs used the Medicaid delivery system as well. The remaining S-SCHIP programs established delivery systems that were separate from Medicaid. Florida elected to use the Medicaid delivery system for its MediKids program—an S-SCHIP program for children through age five—but established a separate delivery system for its Healthy Kids program—an S-SCHIP program for children over age five and their siblings.

States with S-SCHIP programs electing to use the Medicaid delivery system reported choosing this option because it was easy to implement, cost effective for administrative budgets, and less complex for families transitioning between programs or with children in both programs. States with S-SCHIP programs electing to establish a delivery system separate from Medicaid reported that they wanted to create a program more closely associated with private health insurance coverage and less like Medicaid. Some states, such as Montana, North Dakota, and Utah, reported that many providers served both Medicaid and SCHIP enrollees, despite the fact that the S-SCHIP programs had established separate delivery systems. Insofar as the Medicaid and SCHIP programs attract the same providers, continuity of care can be enhanced when children switch programs or when families have children in both programs.

B. USE OF CARVE-OUTS BY SCHIP PROGRAMS

When establishing their SCHIP delivery systems, states reported that they often decided to carve out certain services and deliver them through a separate system. For example, some states delivering care through managed care organizations indicated that they provided certain services through separate risk-based plans, or they paid for these services on an FFS basis, especially if they had concerns about the ability of managed care organizations to provide certain specialized services. Alternatively, some SCHIP programs that primarily used the FFS delivery system established a risk-based carve-out for selected services. States reported that carve-outs may be used to meet various objectives—such as to control costs, improve care, or monitor quality.

Thirty-one states carved out at least one type of service (Table V.2). Frequently, the services carved out were paid on an FFS basis (23 states), although many states contracted with specialized plans that were paid on a capitated basis (15 states). Behavioral health services, including mental health and substance abuse treatment, were the services most frequently carved out. Of the 22 states reporting that they carved out any type of behavioral health services,

TABLE V.2

TYPES OF SERVICES CARVED OUT TO SPECIALTY RISK-BASED PLANS OR FEE-FOR SERVICE, BY STATE AND PROGRAM TYPE

State	Program Type	Services Covered by a Specialty Risk-Based Plan	Services Paid on an FFS Basis
Alabama	M-SCHIP	Inpatient hospital services[a]	NA
	S-SCHIP	Some mental health services	NA
Alaska	M-SCHIP	None	NA
Arizona	S-SCHIP	Behavioral health	None
Arkansas	M-SCHIP	Transportation services	NA
California	M-SCHIP	Dental	None
	S-SCHIP	Dental; vision	None
Colorado	S-SCHIP	None	None
Connecticut	M-SCHIP	None	Birth to Three program; special education
	S-SCHIP	None	None
Delaware	S-SCHIP	None	Pharmacy; mental health and substance abuse beyond the basic benefit of 30 outpatient days
District of Columbia	M-SCHIP	Dental; vision	Behavioral health; long term care
Florida	M-SCHIP	Behavioral health	Behavioral health; dental; substance abuse; vision; nursing facility; ICF/MR; transportation
	S-SCHIP	Behavioral health[b]	None
Georgia	S-SCHIP	None	Dental; vision; mental health
Hawaii	M-SCHIP	Behavioral health; dental	Out-of-state residential treatment services
Idaho	M-SCHIP	None	NA
Illinois	M-SCHIP	None	Dental; vision; extended nursing facility care, ICF/MR; waiver services; audiology; school-based services; family planning; occupational, physical, and speech therapy; in some cases behavioral health
	S-SCHIP	None	Same as above (except waiver services not covered)
Indiana	M-SCHIP	None	Mental health; dental
	S-SCHIP	None	None
Iowa	M-SCHIP	Mental health/substance abuse	None
	S-SCHIP	None	None
Kansas	S-SCHIP	Behavioral health; dental services are contracted out by physical health managed care organizations	Transplants; dental costs over $1,500; antihemophiliac drugs; vaccines
Kentucky	M-SCHIP	None	None
	S-SCHIP	None	None
Louisiana	M-SCHIP	None	NA
Maine	M-SCHIP	None	None
	S-SCHIP	None	None
Maryland	M-SCHIP	Mental health	Occupational, physical, and speech therapy; audiology; targeted case management; services of the rare and expensive case management program; special education plans; personal care; medical day care; transportation
Massachusetts	M-SCHIP	Behavioral health	None
	S-SCHIP	Behavioral health[c]	None
Michigan	M-SCHIP	Community mental health programs; substance abuse coordinating agencies	Dental
	S-SCHIP	Community mental health programs; substance abuse coordinating agencies; dental	None
Minnesota	M-SCHIP	None	Special education plans; mental health; child welfare case management; waiver services; nursing facility; ICF/MR
Mississippi	M-SCHIP	None	NA
	S-SCHIP	None	None
Missouri	M-SCHIP	None	Occupational, physical, and speech therapy; environmental lead tests; lab tests; bone marrow and organ transplants; protease inhibitors; abortion services; mental health/substance abuse
Montana	S-SCHIP	None	None
Nebraska	M-SCHIP	Behavioral/mental health	Dental; pharmacy; nursing facility; personal care aides
Nevada	S-SCHIP	None	Dental; non-emergency transportation; I.H.S. services; hospice; residential treatment; nursing facility stays over 45 days; school-based services
New Hampshire	M-SCHIP	None	None
	S-SCHIP	None	None

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TABLE V.2 ***(continued)***

State	Program Type	Services Covered by a Specialty Risk-Based Plan	Services Paid on an FFS Basis
New Jersey	M-SCHIP	None	Mental health
	S-SCHIP	None	Mental health
New Mexico	M-SCHIP	None	None
New York	M-SCHIP	Yes, but specific services not reported	Yes, but specific services not reported
	S-SCHIP	Yes, but specific services not reported	Yes, but specific services not reported
North Carolina	S-SCHIP	None	Mental health
North Dakota	M-SCHIP	None	Dental; vision; prescription drugs
Ohio	M-SCHIP	None	None
Oklahoma	M-SCHIP	None	Long-term care services after the 30th day; special education plans; tuberculosis follow-up and management; personal care services; transportation services for adolescents self-referring for family planning services; out-of-network child abuse examination services; family planning services for adolescents EPSDT screens and immunizations; services for I.H.S. beneficiaries
Oregon	S-SCHIP	Dental; chemical dependency services	None
Pennsylvania	S-SCHIP	None, but physical health managed care organizations are allowed to subcontract services	None
Rhode Island	M-SCHIP	None	None
South Carolina	M-SCHIP	None	None
South Dakota	M-SCHIP	Dental	NA
	S-SCHIP	None	NA
Tennessee	M-SCHIP	None	None
Texas	M-SCHIP	None	None
	S-SCHIP	NI	NI
Utah	S-SCHIP	None	None
Vermont	S-SCHIP	None	Chiropractic; dental; vision; family planning
Virginia	S-SCHIP	None	School-based physical therapy; hospice; mental health; substance abuse; mental retardation services
Washington	S-SCHIP	None	None
West Virginia	M-SCHIP	None	None
	S-SCHIP	None	NA
Wisconsin	M-SCHIP	None	Chiropractic; dental; prenatal care coordination; targeted case management
Wyoming	S-SCHIP	None	None

SOURCE: Mathematica Policy Research analysis of the title XXI State Evaluations, Table 3.2.3 of the State Evaluation Framework.

NOTE: The type of SCHIP program is as of March 31, 2001. The state evaluations generally present program characteristics as of September 30, 1999.

[a] Alabama reported that all services are paid on a fee-for-service basis, except inpatient hospital services which are paid on a capitated basis.
[b] Children in the MediKids and Children's Medical Services programs receive behavioral health services through a specialty risk-based plan, while children in Healthy Kids receive these services through their regular managed care plan.
[c] Children in CommonHealth access behavioral health services through their regular providers.

NI = Not Implemented.

NA = Not applicable because the program does not use managed care.

11 paid for these services on an FFS basis, and 9 did so through separate, risk-based plans. Two states used a mix of carve-out arrangements:

- The program in Hawaii established a risk-based carve-out for behavioral health services, with the exception of out-of-state residential treatment services, which were paid through an FFS carve-out.
- Florida's use of carve-outs varied among its four SCHIP programs: children enrolled in the M-SCHIP component received behavioral health services through a risk-based plan or FFS; children enrolled in Healthy Kids (the S-SCHIP program for children over age five and their siblings) received behavioral health services through their regular managed care plan; and children enrolled in MediKids (the S-SCHIP program for children through age five) and Children's Medical Services (the S-SCHIP program for children with special health care needs) received these services through a risk-based behavioral health carve-out.

It was also fairly common for states to separate dental services from other services. Among the 15 states reporting any type of carve-out for dental services, 9 paid for these services on an FFS basis and 5 developed separate capitated plans for dental services. One state, Michigan, paid for dental services provided to its M-SCHIP enrollees on an FFS basis but contracted with risk-based dental plans for its S-SCHIP enrollees.

SCHIP programs also carved out a variety of other services. Typically, these services were paid on an FFS basis.

- Delaware, Nebraska, and North Dakota reported paying for all prescription medications on an FFS basis. Kansas paid for antihemophiliac drugs on an FFS basis.
- Long-term care services, such as ICF/MR and nursing facility services, were paid on an FFS basis in the District of Columbia, Florida, Illinois, Minnesota, Nebraska, Nevada, and Oklahoma.
- Vision services were carved out through separate risk-based plans in California and the District of Columbia, but paid on an FFS basis in Florida, Georgia, Illinois, North Dakota, and Vermont.
- Delaware and Kansas used FFS carve-outs to provide wraparound benefits when a child exhausted a covered benefit. Delaware paid on an FFS basis for mental health and substance abuse services that were beyond the basic benefit of 30 outpatient days. Kansas covered dental costs over $1,500 on an FFS basis.

C. CHALLENGES IN ESTABLISHING AND MAINTAINING PROVIDER NETWORKS

Many states reported that they faced challenges in establishing and maintaining adequate provider networks, regardless of whether the SCHIP program used the Medicaid delivery system or established its own system. These reported challenges included providing families with a choice of health plans and ensuring an adequate number of providers for enrollees (particularly safety net providers). Some states reported specific concerns with chronic shortages of dental and vision services, and gaps in provider networks in rural areas.

States that used a system of managed care typically placed the responsibility of ensuring adequate provider networks on the managed care organizations. To monitor network adequacy, some states indicated that they required managed care organizations to submit data demonstrating that they had adequate provider capacity with which to serve their target population and that families could be offered a choice of providers. For example, New York's S-SCHIP program routinely required managed care organizations to submit provider network information for review. Networks were evaluated based on time/distance standards and specialty composition. The state used mapping technology to assess the adequacy of provider networks in assuring access for all enrollees. In addition, any plan requesting an expansion of its service area was required to demonstrate adequate provider capacity.

A few states reported special efforts to ensure adequate participation of safety net providers—such as community health centers and public hospitals—in managed care provider networks. Because these providers may play a crucial role in providing care to low-income individuals, some states have developed new programs and policies designed to address the challenges faced by these providers.

- The S-SCHIP program in California offered contract incentives for plans that included safety net providers in their provider networks. Health plans with the highest percentage of safety net providers in their networks were designated Community Provider Plans (CPPs) and families that chose to enroll in CPPs received a $3 per child premium discount. The state reported that 18 health plans were designated as CPPs in at least one county and that 42 percent of all enrollees in Healthy Families were enrolled in a CPP. In addition, 38 percent chose a safety net provider as their primary care physician.
- Alabama also made efforts to ensure the inclusion of community health centers in the provider network serving its S-SCHIP enrollees. The program reported that direct reimbursement of ancillary providers, such as nurse practitioners, increased its provider network and encouraged the use of community health centers in rural areas.
- The M-SCHIP program in Wisconsin required managed care organizations to have signed Memoranda of Understanding (MOUs) with county mental health agencies. They reported that this requirement ensured access to mental health services, improved coordination, and enhanced communication between MCOs and these providers.

Of the 43 states using managed care in their SCHIP program, all but five contracted with more than one plan. Some states—such as Arizona, California, Florida, Michigan, New York, Oregon, and Wisconsin—contracted with 10 or more plans (Table V.3). Statewide managed care systems have been implemented for at least one component of the SCHIP program in 24 states. In addition, 30 states used mandatory enrollment for managed care. In some states, mandatory enrollment was conditional on whether families had a choice of at least two plans. Although New Hampshire and Montana had mandatory enrollment, each had only one plan serving children in their S-SCHIP programs.

Several states reported specific efforts to increase the number of managed care organizations participating in their SCHIP program. These efforts reflected the overall desire to increase the penetration of managed care and provide families with more choices, as well as reduce the program's vulnerability to a changing market.

TABLE V.3

CHARACTERISTICS OF MANAGED CARE SYSTEMS, BY STATE AND PROGRAM TYPE

		Characteristics of Managed Care System			
State	Program Type	Number of Managed Care Organizations	Statewide	Mandatory Enrollment	Dominant Type of Delivery System[a]
Arizona	S-SCHIP	12	Yes	Yes	Managed Care
California	M-SCHIP	26	Yes	Yes	Mixed System
	S-SCHIP	25[b]	Yes	No	Managed Care
Colorado	S-SCHIP	6	No	Yes	Managed Care
Connecticut	M-SCHIP	4	Yes	Yes	Managed Care
	S-SCHIP	3	Yes	Yes	Managed Care
Delaware	S-SCHIP	3	Yes	Yes	Managed Care
District of Columbia	M-SCHIP	7	Yes	Yes	Managed Care
Florida	M-SCHIP	13	No	No	Mixed System
	S-SCHIP	15	Yes[c]	Yes[c]	Managed Care
Hawaii	M-SCHIP	6	Yes	Yes	Managed Care
Illinois	M-SCHIP	8	No	No	FFS
	S-SCHIP	5	No	No	FFS
Indiana	M-SCHIP	2	Yes	Yes	Mixed System
	S-SCHIP	2	Yes	Yes	Mixed System
Iowa	M-SCHIP	4	No	No	Mixed System
	S-SCHIP	2	No	No[d]	Managed Care
Kansas	S-SCHIP	2	Yes	Yes	Managed Care
Kentucky	M-SCHIP	2	No	Yes	PCCM
	S-SCHIP	DNR	No	No	PCCM
Maine	M-SCHIP	1	No	No	Mixed System
	S-SCHIP	1	No	No	Mixed System
Maryland	M-SCHIP	8	Yes	Yes	Managed Care
Massachusetts	M-SCHIP	4	Yes	No	Mixed System
	S-SCHIP	4	Yes	No	Mixed System
Michigan	M-SCHIP	27	Yes	Yes	Mixed System
	S-SCHIP	13	Yes	Yes	Managed Care
Minnesota	M-SCHIP	8	No	Yes	Mixed System
Mississippi	M-SCHIP	0	NA	NA	PCCM
	S-SCHIP	DNR	DNR	DNR	Managed Care
Missouri	M-SCHIP	9	No	Yes	Mixed System
Montana	S-SCHIP	1	Yes	Yes	Managed Care
Nebraska	M-SCHIP	2	No	Yes	Managed Care
Nevada	S-SCHIP	3	No	Yes	Managed Care
New Hampshire	M-SCHIP	1	Yes	No	FFS
	S-SCHIP	1	Yes	Yes	Managed Care
New Jersey	M-SCHIP	6	Yes	Yes	Managed Care
	S-SCHIP	6	Yes	Yes	Managed Care
New Mexico	M-SCHIP	3	Yes	Yes	Managed Care
New York	M-SCHIP	36	Yes	No	FFS
	S-SCHIP	32	Yes	No	Managed Care
North Dakota	M-SCHIP	1	No	No	PCCM
	S-SCHIP	NI	NI	NI	NI
Ohio	M-SCHIP	11	No	No[e]	PCCM
Oklahoma	M-SCHIP	4[f]	No	Yes	Managed Care
Oregon	S-SCHIP	15	Yes	Yes	Managed Care
Pennsylvania	S-SCHIP	5	Yes	Yes	Managed Care
Rhode Island	M-SCHIP	3	Yes	Yes	Managed Care
South Carolina	M-SCHIP	1[g]	No	No	FFS
Tennessee	M-SCHIP	DNR	Yes	No	Managed Care
Texas	M-SCHIP	DNR[h]	No	DNR	FFS
	S-SCHIP	NI	NI	NI	Managed Care
Utah	S-SCHIP	4[i]	Yes	Yes	Managed Care
Vermont	S-SCHIP	2	Yes	Yes	Mixed System

Table V.3 *(continued)*

		Characteristics of Managed Care System			
State	Program Type	Number of Managed Care Organizations	Statewide	Mandatory Enrollment	Dominant Type of Delivery System[a]
Virginia	S-SCHIP	7	No	Yes	Mixed System
Washington	S-SCHIP	2	No	No[j]	Mixed System
West Virginia	M-SCHIP	2	No	No[k]	FFS
	S-SCHIP	0	NA	NA	
Wisconsin	M-SCHIP	15	No	Yes	Managed Care
Wyoming	S-SCHIP	DNR	Yes	No	FFS

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations, Table 3.2.3 of the State Evaluation Framework, and Annual Reports for 2000.

NOTE: The type of SCHIP program is as of March 31, 2001. The state evaluations generally present program characateristics as of September 30, 1999. The dominant delivery system was based on SEDS data from the fourth quarter of Federal fiscal year 2000.

[a] The dominant delivery system was based on SEDS data from the fourth quarter of Federal fiscal year 2000. A system was considered dominant if at least two-thirds of children were enrolled in that system; otherwise the system was considered to be mixed. The types of delivery systems were based on Table 3.2.3 from the title XXI State Evaluation Framework.

[b] Applies to Healthy Families only. AIM, the program for pregnant women and infants, contracted with nine managed care organizations.

[c] Applies to Healthy Kids only. The managed care delivery system for MediKids was not statewide and enrollment was mandatory only when at least two managed care organizations served the county.

[d] Except when managed care is the only delivery system offered in the county.

[e] Except in some metropolitan counties.

[f] Managed care organizations served only urban areas.

[g] South Carolina had a Physicians Enhancement Program that paid physicians set rates based on the age and gender of the patient.

[h] Texas reported that managed care organizations served 84 counties and exclusive provider organizations served 170 counties.

[i] One managed care organization subsequently withdrew, leaving only three managed care organizations to participate in SCHIP.

[j] Except in the three counties that offered two plan options.

[k] Except in two counties.

DNR = Did Not Report.

NI = Not Implemented.

- California's S-SCHIP program reported that it was extremely successful in achieving managed care penetration and providing families with a choice of health plans. Ninety-seven percent of families had a choice of two or more plans, while 57 percent had a choice of at least seven plans.

- Colorado wished to expand the availability of managed care to all counties, but this has proven difficult, due to obstacles to creating managed care options in rural areas of the state. For example, one managed care organization initially obtained a statewide service area license, but then withdrew from the Medicaid and SCHIP programs. Colorado reported that market volatility and health plan financial status, combined with the small size of the eligible SCHIP population, will likely continue to limit its ability to expand managed care. In response to these market pressures, the state began investigating innovative risk-pooling arrangements and other initiatives.

- The SCHIP delivery systems in Montana and Nevada also faced challenges in increasing the number of plans serving SCHIP enrollees. The Montana program had only one managed care organization that served all SCHIP enrollees. The state attempted, without success, to negotiate additional plan options with other insurers, and planned to continue its negotiation effort. Nevada faced a similar situation; only one plan served the northern part of the state, and no plans were available for children in rural areas.

- Maine enrolled about 15 percent of S-SCHIP enrollees in a single managed care organization. The state had expected higher levels of managed care enrollment, but this was not possible because the state was unable to negotiate a contract with more than one plan. The single plan operated in seven counties where enrollment was voluntary. In addition, nine counties had a PCCM plan.

- Mississippi initially implemented a pilot program that established managed care in six counties. The four managed care organizations participating in the pilot eventually discontinued services and withdrew, citing a nonviable market.

- The managed care markets in Ohio and Utah were volatile during the first years of their SCHIP programs. In Ohio, three managed care organizations left the Medicaid program due to court-ordered liquidations. In response, Ohio changed some of its contracting policies so that managed care organizations could contract on a multicounty basis. In Utah, one of the four managed care organizations serving SCHIP enrollees left the market for financial reasons resulting from relatively low enrollment. Utah reported that significant efforts were made to ensure a seamless transition of the enrollees in this plan to other plans. This effort included notification letters with follow-up telephone calls.

- The Kansas legislature mandated only managed care for the SCHIP delivery system. This presented challenges in a state that lacked a strong managed care presence in either the commercial or public health insurance markets. The managed care organizations had problems maintaining adequate provider networks due to geography, provider shortages, or resistance to the managed care system.

Several programs noted specific efforts to improve individual provider participation in SCHIP through the use of enhanced provider reimbursements:

- Legislative actions in Ohio and Louisiana resulted in the appropriation of additional funds for increased provider fees (non-institutional providers in Ohio and physicians in Louisiana). Both states reported that ensuring adequate access to care drove the decision to increase fees for these providers.
- South Carolina developed two programs that offered enhanced provider fees through its FFS system. In one program, providers received enhanced fees for offering more hours of access, while the other program provided enhanced fees for care management and gatekeeper oversight.
- Missouri increased reimbursement for dental services in each of the past three years, in order to increase participation among dental providers.
- California and Alabama used specific contracting policies to ensure adequate payment rates for providers. In Alabama, SCHIP enrollees were covered by a plan managed by Blue Cross Blue Shield (BCBS) of Alabama, which covered 82 percent of people insured in the state. The BCBS provider network was extensive, and providers serving SCHIP enrollees were reimbursed according to the BCBS preferred provider rates. California addressed the challenge of assuring adequate provider participation in rural areas through demonstration projects designed to develop stronger partnerships between rural providers and health, dental, and vision plans.

In addition to increased reimbursement and enhanced fees, some states reported increasing outreach and education efforts to inform providers about the program. Dentists were a primary focus of many of these efforts:

- Alaska increased ties between the Medicaid program and the state's provider associations to improve access to dental services and well-child care.
- Kentucky formed a workgroup to assess provider adequacy on an ongoing basis and to develop a plan for recruiting additional providers, as needed. They reported that this effort was successful in the recruitment of dental providers.
- The SCHIP program in Missouri reported efforts to recruit dentists, which included educational seminars, streamlined reporting requirements, and assistance with broken appointments.
- Nevada's efforts focused on provider workshops to educate current and potential providers about the Medicaid and SCHIP programs, particularly in rural areas where provider shortages are chronic.

D. CONCLUSION

Due to a variety of circumstances, managed care was not the dominant delivery system among SCHIP programs. Although 43 states had a managed care delivery system in place, it was the dominant system in 20 states, and the sole system in 8 states. PCCM and FFS delivery systems played a dominant role in serving SCHIP enrollees in 14 states. Seventeen states used a mix of delivery systems to serve SCHIP enrollees. All M-SCHIP components relied on the Medicaid delivery system; 16 of the 34 S-SCHIP programs used it as well. The remaining 18 S-SCHIP programs established delivery systems that were separate from Medicaid. Some states reported that the Medicaid and SCHIP programs attracted the same providers, facilitating continuity of care when children were transferred between programs due to changes in family circumstances or when families had children in more than one program.

When establishing their SCHIP delivery systems, states often decided to carve out certain services and deliver them through a separate system. Thirty-one states carved out at least one type of service, and most paid for carved-out services on a fee-for-service basis. Twenty-two states carved out behavioral health services and 15 states carved out dental services. States did not report on access to and coordination of care provided through carve-outs under SCHIP.

Many states reported that they faced challenges in establishing and maintaining adequate provider networks, regardless of whether the SCHIP program used the Medicaid delivery system or had established its own system. These challenges included providing families with a choice of health plans and ensuring an adequate number of providers for enrollees, particularly safety net providers. Based on the state evaluations, it appears that many states were proactive in meeting the challenges they faced in developing and maintaining their delivery systems. State efforts included designing mechanisms to monitor network capacity, encouraging participation of safety net providers, and improving health plan and provider participation.

Nevertheless, instability in the health care marketplace may continue to present challenges to SCHIP programs and their ability to meet the needs of enrollees and their families. Some specific concerns articulated by states were chronic shortages of dental and vision services, and gaps in provider networks in rural areas. Most states reported that they will be gathering consumers' assessments of their health plans and providers to gain a better understanding of how well SCHIP delivery systems are meeting enrollees' needs.

VI. COORDINATION BETWEEN SCHIP AND OTHER PUBLIC PROGRAMS

Title XXI required states to coordinate administration of their SCHIP programs with other public health insurance programs, and to ensure that children eligible for Medicaid, in particular, are appropriately enrolled in that program. In addition, coordination with Medicaid has proven to be essential because certain families tend to move back and forth between Medicaid and SCHIP or because they have one or more children enrolled in each program.

Successful coordination between SCHIP and other public programs—such as title V Maternal and Child Health (MCH) programs, the National School Lunch Program (NSLP), and the Special Supplemental Food Program for Women, Infants and Children (WIC)—can also contribute to a state's ability to provide health insurance coverage to as many uninsured, low-income children as possible. These programs often serve the same populations that states sought to cover under SCHIP; therefore, coordination was important to informing uninsured families about SCHIP and facilitating enrollment. Moreover, effective coordination can help to avoid the confusion on the part of the general public that may result from having multiple programs that assist low-income families.

Title XXI (section 2108(b)(1)(D)) required states to review and assess their activities to coordinate their SCHIP programs with other public programs providing health care and health care financing, including Medicaid and MCH services. Section A of this chapter outlines strategies used by S-SCHIP programs to meet the title XXI statutory requirements to coordinate with Medicaid. Section B describes coordination efforts with other public programs that serve low-income children and their families.

A. COORDINATION WITH MEDICAID

In designing SCHIP, Congress intended that states use SCHIP funds to extend coverage to uninsured individuals who were not eligible for existing public or private programs. In addition, Congress directed states to coordinate with their Medicaid programs. For example, the legislation (section 2102(b)(3)(A)) mandated that states have a process to ensure that only SCHIP-eligible children are covered under SCHIP. The legislation (section 2102(b)(3)(B)) also required that SCHIP programs implement procedures to screen applicants for Medicaid eligibility and enroll in Medicaid those who are determined to be eligible for Medicaid during intake and follow-up screening. These requirements are commonly referred to as "screen and enroll."

For the states that opted to implement M-SCHIP-only programs, coordination with Medicaid was more straightforward, since M-SCHIP programs are an expansion of Medicaid. On the other hand, coordination with Medicaid was more challenging for the states with S-SCHIP programs. From a practical perspective, S-SCHIP programs must first screen applicants for Medicaid eligibility. Under title XXI, S-SCHIP programs cannot simply refer potentially eligible families to Medicaid. If a child appears to be Medicaid-eligible, an official determination of Medicaid eligibility must occur before a SCHIP eligibility determination can be made. Screen and enroll attempts to ensure that children receive coverage under the correct program and that the appropriate Federal matching rate is applied (states receive an enhanced matching rate for SCHIP enrollees).

Effective coordination may also facilitate retention of coverage when families' circumstances change. Low-income families often live in dynamic environments, where income and other eligibility determinants fluctuate significantly. By coordinating eligibility redetermination for SCHIP and Medicaid, states may help families retain coverage when they need to move from one program to the other.

All states with S-SCHIP programs coordinated with Medicaid programs in multiple ways.[1] The most common coordination efforts were designed to simplify the enrollment process, through the use of joint applications, combined outreach, and shared administration. Chapter IX includes a more detailed discussion of state success in assisting children to become enrolled in Medicaid, as a result of SCHIP outreach and enrollment efforts.

1. Joint Applications

Joint applications for S-SCHIP and Medicaid are one tool states can use to streamline eligibility determination. Joint applications can allow states to screen eligibility for Medicaid and S-SCHIP from a single application. Joint applications, depending upon how they are designed, can prevent families from having to provide duplicate information to Medicaid and S-SCHIP, going to multiple offices, or completing additional paperwork.

Of the 30 states with S-SCHIP programs, 25 indicated that they used a joint application with Medicaid (Table VI.1). These states developed a simplified, shortened application with fewer questions and fewer verification requirements than traditional Medicaid applications. States said that the benefits of having more people submit applications outweighed the possible risks of enrolling ineligible children.

A few states with S-SCHIP programs also designed applications that permitted determinations of eligibility for other public assistance programs, such as TANF, WIC, and Food Stamps. For example, New York, Vermont, and Washington used the same application for their

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[1] This section is based on the responses of 30 states that had implemented S-SCHIP programs at the time they completed their state evaluations.

TABLE VI.1

COORDINATION BETWEEN SEPARATE SCHIP PROGRAMS AND MEDICAID

State	Program Type	Joint Application	Outreach	Administration	Data Collection	Quality Assurance	Service Delivery	Procurement	Contracting
Total		25	26	25	25	24	23	18	19
Alabama	COMBO	✓	✓	✓	✓	✓	✓		
Arizona	S-SCHIP		✓	✓	✓	✓	✓		✓
California	COMBO	✓	✓	✓	✓		✓	✓	✓
Colorado	S-SCHIP	✓	✓		✓		✓	✓	
Connecticut	COMBO	✓	✓	✓	✓	✓	✓	✓	✓
Delaware	S-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓
Florida	COMBO	✓	✓	✓	✓	✓	✓		✓
Georgia	S-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓
Illinois	COMBO	✓	✓	✓	✓	✓	✓	✓	✓
Iowa	COMBO	✓	✓	✓	✓	✓	✓		
Kansas	S-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓
Kentucky	COMBO	✓		✓	✓	✓	✓	✓	✓
Maine	COMBO	✓	✓	✓	✓	✓	✓	✓	✓
Massachusetts	COMBO	✓	✓	✓				✓	
Michigan	COMBO	✓	✓	✓		✓		✓	✓
Mississippi	COMBO		✓				✓		
Montana	S-SCHIP	✓		✓					
Nevada	S-SCHIP		✓	✓	✓	✓	✓		✓
New Hampshire	COMBO	✓	✓		✓	✓			
New Jersey	COMBO	✓	✓	✓	✓	✓	✓	✓	✓
New York	COMBO	✓	✓		✓	✓	✓	✓	
North Carolina	S-SCHIP	✓		✓	✓	✓		✓	✓
Oregon	S-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓
Pennsylvania	S-SCHIP		✓	✓	✓	✓			
Utah	S-SCHIP		✓		✓				✓
Vermont	S-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓
Virginia	S-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓
Washington	S-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓
West Virginia	S-SCHIP	✓		✓		✓	✓		
Wyoming[a]	S-SCHIP	✓	✓	✓	✓	✓	✓		

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations, Section 3.5 of the State Evaluation Framework.

NOTE: The type of SCHIP program is as of March 31, 2001. The state evaluations generally present program characteristics as of September 30, 1999. Analysis includes only 30 States with separate SCHIP programs as of March 31, 2000.

S-SCHIP, Medicaid, and WIC programs. Maine's Department of Human Services developed a shortened, one-page application for Medicaid and S-SCHIP but used a longer application (six pages), which required more financial information, to determine eligibility for TANF and Food Stamps.[2]

2. Coordination of Outreach Activities

To increase awareness among low-income families about SCHIP *and* Medicaid (especially in ethnic and rural communities), most states reported developing coordinated outreach efforts. States also coordinated activities to facilitate enrollment, such as by providing assistance in describing available programs to families and in completing applications. States indicated that such coordination helped minimize confusion about health insurance options for low-income children.

Twenty-six of the 30 states with S-SCHIP programs reported coordinating outreach efforts with Medicaid (Table VI.1).

- New Hampshire coordinated outreach between S-SCHIP and Medicaid by marketing the programs under a single name, Healthy Kids.
- Arizona coordinated outreach efforts by combining its outstationed eligibility staff for Medicaid and S-SCHIP. The state placed staff at Federally Qualified Health Centers (FQHCs), in hospitals serving disproportionate numbers of low-income families, and at juvenile detention centers. Staff provided assistance to families applying for Medicaid and/or KidsCare, thus making the application process more effective and efficient. In addition, FQHC staff received training and literature about eligibility issues.
- Washington coordinated its outreach efforts among the Medical Assistance Administration, the Department of Health, and the Office of the Superintendent of Public Instruction. These agencies also worked together to coordinate client referrals to ensure that children became enrolled in the appropriate program.

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[2] Other examples of state efforts to simplify the eligibility determination and redetermination processes were presented in MPR's first annual report (Rosenbach et al. 2001).

- Wyoming used funds from the Robert Wood Johnson Foundation's Covering Kids grant to simultaneously promote both Medicaid and Wyoming Kid Care.

3. Coordination of Administration

Twenty-five states reported coordinating administrative activities between Medicaid and S-SCHIP programs (Table VI.1), such as eligibility determination, health plan enrollment, marketing, quality assurance, and finance. In several states, such as Iowa, Kentucky, and Maine, the S-SCHIP program was administered by the state Medicaid agency. Administrative coordination can also mean that a single unit determines eligibility. Some states reported that they found it easier to transfer children between programs when their eligibility status changed as a result of administrative coordination. For example:

- In Georgia, families mailed PeachCare applications to a central office. A contractor screened each application first for Medicaid eligibility, and forwarded applications that were potentially Medicaid-eligible to the State Department of Medical Assistance for review. If the applicants were determined not to be Medicaid-eligible, the contractor was notified, and then completed the eligibility process for PeachCare.
- In Oregon, applications for S-SCHIP and Medicaid were mailed to the Oregon Health Plan (OHP) offices, where employees screened the applications first for Medicaid eligibility, then for S-SCHIP eligibility.
- In Utah, the same eligibility staff and eligibility determination system were used for the S-SCHIP and Medicaid programs. The state used a "cascading" approach, in which applications were reviewed first to see if they qualified under more restrictive Medicaid eligibility standards and, if so, were enrolled in Medicaid. If not, they were then reviewed again for eligibility under less restrictive S-SCHIP standards.

4. Data Collection and Quality Assurance

Some states reported that coordination of data collection and quality assurance enabled them to better analyze patterns of enrollment, access, and utilization by their SCHIP population, in comparison with the traditional Medicaid population or the private health insurance market. In addition, states reported that coordination in this area can minimize the paperwork burden on providers, if the data requirements are the same for Medicaid and SCHIP.

Among the 30 states with S-SCHIP programs, 25 states reported coordinating data collection between S-SCHIP and Medicaid, whereas 24 states reported coordinating quality assurance between their S-SCHIP and Medicaid programs (Table VI.1). Some states coordinated data collection and quality assurance by using the same data systems. Others used different data systems, but the two were compatible (for example, they shared data elements).

As an example, Kansas coordinated data collection and monitored the quality of its programs by using a single eligibility system, called the Kansas Automated Eligibility and Child Support Enforcement System (KAECSES). KAECSES maintained eligibility information for all cash, medical, and Food Stamp programs in the state, and allowed the state to monitor characteristics of Medicaid and SCHIP enrollees. Kansas noted the benefits of using the same staff to collect and analyze the data. The state hoped to expand the scope of its analysis in the future by linking S-SCHIP data with vital statistics records.

5. Service Delivery, Procurement, and Contracting

As mentioned in Chapter V, title XXI allowed states considerable flexibility in designing a delivery system to serve S-SCHIP enrollees, and many states have used a combination of approaches. Some states elected to use their Medicaid delivery systems, while others developed separate delivery systems that coordinated with Medicaid. Twenty-three states reported coordinating service delivery between S-SCHIP and Medicaid programs, to facilitate the continuity of care for children who transferred between Medicaid and S-SCHIP (Table VI.1).

Coordination of procurement and contracting is another option that some states pursued. Nineteen of the 30 states with S-SCHIP programs reported that they coordinated contracting procedures with Medicaid, while 18 states reported coordinating procurement efforts. Connecticut reported several benefits of coordinating contracts and procurement for its HUSKY program. HUSKY contracted with three of the same managed care organizations for HUSKY A

(M-SCHIP) and HUSKY B (S-SCHIP). The coordination minimized discontinuities in care for members moving from HUSKY A to B, and vice versa. Coordination also made administrative tasks more efficient. Key administrative staff worked on contracting and procurement for HUSKY A, HUSKY B, and HUSKY Plus.

B. COORDINATION WITH OTHER PROGRAMS

In addition to coordinating with Medicaid, SCHIP programs coordinated with several other programs that targeted low-income families. Research has shown that uninsured children participate in other public programs that serve low-income families, and therefore, that coordination with these programs is important. For example, the Urban Institute found that about 3.9 million uninsured, low-income children participated in the National School Lunch Program and that 1.5 million participated in WIC (Kenney et al. 1999). The research also found that outreach to children participating in other public programs—who are potentially eligible for but not enrolled in Medicaid or SCHIP—may be particularly fruitful because their families have already demonstrated a willingness to participate in public programs. The table below summarizes coordination strategies used by SCHIP programs.

	Number of States Coordinating between SCHIP and:		
	MCH	Schools/NSLP	WIC
Total	**40**	**23**	**22**
Outreach	40	23	22
Eligibility Determination	13	6	3
Administration	12	3	4
Data Collection	10	3	5
Quality Assurance	6	1	1
Service Delivery	13	1	1
Procurement	2	0	0
Contracting	2	0	1

The most common form of coordination between SCHIP and other programs was outreach. States appear to have focused less on coordination of eligibility determination, service delivery, and monitoring/evaluation activities with these programs.

1. Coordination with Maternal and Child Health and Other Public Health Programs

Forty states reported that their SCHIP programs coordinated with title V MCH programs (Table VI.2). Title V MCH programs aim to establish a health care delivery infrastructure and coordinate services focusing on the special needs of children. Title V funds are used to promote family-centered and community-based coordinated care. MCH programs also establish standards of care for children with special health care needs. Examples of coordination between SCHIP and MCH programs included the following:

- In New Jersey, MCH and SCHIP administrators worked together to identify nearly 15,000 children in the MCH files who potentially were eligible for KidCare. The state then established a performance-based incentive plan that encouraged caseworkers to enroll as many of these children as possible.
- Indiana's SCHIP and MCH programs coordinated in three ways. First, Indiana's MCH program operated a family helpline, which provided health care information and referrals through a toll-free telephone number. The family helpline staff screened clients for Hoosier Healthwise eligibility and provided appropriate referrals. Second, MCH grantees documented referrals to SCHIP and recorded that information in the project database. This allowed administrators to follow up on the referrals at a later date. Finally, seven MCH clinics served as SCHIP enrollment centers.
- In Pennsylvania, a task force was formed to develop and implement a quality assurance system to be executed through SCHIP in coordination with Medicaid and MCH. The task force included medical directors from SCHIP, the state Department of Health, and SCHIP managed care contractors.
- In Alabama, because of the large number of nurse practitioners in the MCH service delivery system, the ALL Kids Program broadened its provider networks to include non-physician providers.

Many states reported that their S-SCHIP programs offered benefits that were more limited than those offered by traditional Medicaid, to keep costs low and allow as many children as

TABLE VI.2

COORDINATION BETWEEN SCHIP AND MATERNAL AND CHILD HEALTH (MCH) PROGRAMS

State	Program Type	Outreach	Eligibility Determination	Administration	Data Collection	Quality Assurance	Service Delivery	Procurement	Contracting
Total		40	13	12	10	6	13	2	2
Alabama	COMBO	✓			✓		✓		
Alaska [a]	M-SCHIP	✓							
Arizona	S-SCHIP	✓							
Arkansas	M-SCHIP	✓							
California	COMBO								
Colorado	S-SCHIP	✓							
Connecticut	COMBO	✓	✓	✓	✓	✓			✓
Delaware	S-SCHIP	✓	✓		✓				
District of Columbia	M-SCHIP								
Florida	COMBO	✓	✓	✓	✓	✓	✓	✓	✓
Georgia	S-SCHIP								
Hawaii	M-SCHIP								
Idaho	M-SCHIP	✓		✓					
Illinois	COMBO	✓					✓		
Indiana	COMBO	✓	✓				✓		
Iowa	COMBO	✓					✓		
Kansas	S-SCHIP	✓	✓				✓		
Kentucky	COMBO								
Louisiana	M-SCHIP	✓		✓					
Maine	COMBO								
Maryland	M-SCHIP	✓							
Massachusetts	COMBO	✓	✓	✓				✓	
Michigan	COMBO	✓							
Minnesota	M-SCHIP	✓	✓	✓			✓		
Mississippi	COMBO	✓					✓		
Missouri	M-SCHIP	✓			✓		✓		
Montana	S-SCHIP								
Nebraska	M-SCHIP	✓	✓						
Nevada	S-SCHIP	✓							
New Hampshire	COMBO	✓			✓	✓			
New Jersey	COMBO	✓			✓	✓			
New Mexico	M-SCHIP	✓	✓	✓					
New York	COMBO	✓	✓				✓		
North Carolina	S-SCHIP	✓							
North Dakota	COMBO	✓			✓				
Ohio	M-SCHIP	✓	✓						
Oklahoma	M-SCHIP								
Oregon	S-SCHIP	✓							
Pennsylvania	S-SCHIP	✓		✓		✓			
Rhode Island	M-SCHIP	✓							
South Carolina	M-SCHIP	✓		✓			✓		
South Dakota	COMBO	✓			✓	✓			
Tennessee	M-SCHIP	✓							
Texas	COMBO	✓	✓						
Utah	S-SCHIP								
Vermont	S-SCHIP								
Virginia	S-SCHIP	✓					✓		
Washington	S-SCHIP	✓	✓	✓					
West Virginia	S-SCHIP								
Wisconsin	M-SCHIP	✓		✓	✓		✓		
Wyoming	S-SCHIP	✓		✓					

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations, Section 3.5 of the State Evaluation Framework.

NOTE: The type of SCHIP program is as of March 2001. The state evaluations generally present program characteristics as of September 30, 1999. Maine and Oklahoma did not complete this section.

[a] Alaska also provides application assistance and referral assistance.

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possible to be insured, while avoiding substitution of private health insurance coverage. Thus, some states reported coordinating with public health and mental health programs to ensure that children with special health care needs had access to comprehensive services, beyond those offered by their SCHIP programs.

- California's SCHIP program coordinated with county mental health departments to provide specialized services for children with serious emotional disturbances. Health plans referred children who required additional mental health services beyond what was included in the SCHIP benefit package under a formal memorandum of understanding.
- Florida established a state-level administrative council to coordinate the SCHIP program with several of the state's public health and social service programs. The council included representatives from a variety of the state's social service programs, including the Department of Health, Agency for Health Care Administration, Department of Children and Families, Department of Insurance, and Florida Healthy Kids Corporation. The council was mandated to review and make recommendations about the implementation and operation of the program.

2. Coordination with Schools and the National School Lunch Program

Following the implementation of SCHIP, considerable attention has been focused on the opportunities to reach potentially eligible children through schools, specifically through the NSLP (DHHS 2000). The NSLP provides cash and commodity assistance to help schools make low-cost or free meals and milk available to all school children. Children in families with income below 130 percent of poverty are eligible for free meals and milk; those with incomes between 130 and 185 percent of poverty are eligible for reduced-price meals. The NSLP covers 24 million children nationally up to the 12th grade.

Twenty-three states reported that they coordinated their SCHIP programs with the NSLP, or with schools more generally (Table VI.3). This has proven to be an effective policy, largely because of the extent to which the two programs target the same population. The U.S. Department of Education spearheaded the "Insure Kids Now! Through Schools" campaign to

TABLE VI.3

COORDINATION BETWEEN SCHIP AND SCHOOLS (INCLUDING SCHOOL LUNCH PROGRAMS)

State	Program Type	Outreach	Eligibility Determination	Administration	Data Collection	Quality Assurance	Service Delivery	Procurement	Contracting
Total		23	6	3	3	1	1	0	0
Alabama	COMBO								
Alaska	M-SCHIP	✓							
Arizona	S-SCHIP								
Arkansas	M-SCHIP	✓							
California	COMBO								
Colorado	S-SCHIP	✓	✓	✓	✓				
Connecticut	COMBO								
Delaware	S-SCHIP	✓	✓						
District of Columbia	M-SCHIP	✓							
Florida	COMBO								
Georgia	S-SCHIP								
Hawaii	M-SCHIP	✓							
Idaho	M-SCHIP								
Illinois	COMBO	✓							
Indiana	COMBO	✓							
Iowa	COMBO	✓							
Kansas	S-SCHIP								
Kentucky	COMBO								
Louisiana	M-SCHIP	✓							
Maine	COMBO								
Maryland	M-SCHIP								
Massachusetts	COMBO								
Michigan	COMBO	✓							
Minnesota	M-SCHIP								
Mississippi	COMBO								
Missouri	M-SCHIP	✓							
Montana	S-SCHIP								
Nebraska	M-SCHIP	✓							
Nevada	S-SCHIP	✓							
New Hampshire	COMBO								
New Jersey	COMBO	✓			✓				
New Mexico	M-SCHIP	✓	✓	✓	✓	✓			
New York	COMBO								
North Carolina	S-SCHIP								
North Dakota	COMBO								
Ohio	M-SCHIP								
Oklahoma	M-SCHIP								
Oregon	S-SCHIP								
Pennsylvania	S-SCHIP	✓							
Rhode Island	M-SCHIP	✓	✓						
South Carolina	M-SCHIP	✓							
South Dakota	COMBO								
Tennessee	M-SCHIP	✓							
Texas	COMBO								
Utah	S-SCHIP								
Vermont	S-SCHIP								
Virginia	S-SCHIP	✓	✓				✓		
Washington	S-SCHIP	✓	✓	✓					
West Virginia	S-SCHIP								
Wisconsin	M-SCHIP								
Wyoming	S-SCHIP	✓							

SOURCE: Mathematica Policy Research Analysis of title XXI State Evaluations, Section 3.5 of the State Evaluation Framework.

NOTE: The type of SCHIP program is as of March 31, 2001. The state evaluations generally present program characteristics as of September 30, 1999. Maine and Oklahoma did not complete this section.

encourage schools to conduct outreach to families about health insurance options (including SCHIP). In addition, SCHIP programs can enter into agreements with agencies that administer the NSLP to obtain names of participating children who potentially are eligible for SCHIP. Many states, for example, attempted to target families as they applied for the NSLP.[3]

- Indiana's application for school lunches included a box for parents to check if they wished to receive more information about SCHIP. This allowed the state to identify families who would benefit from SCHIP, while still maintaining their privacy.
- In South Carolina, applications for school lunch programs in many districts requested parents' permission to share information with SCHIP plans. The state's Department of Health and Human Services screened the names submitted by the school lunch programs and mailed applications to 3,800 families who indicated interest in SCHIP.
- Illinois reported that the state has been working with the Chicago Public Schools to identify potentially eligible families and to assist in their applications.

3. Coordination with the Special Supplemental Food Program for Women, Infants, and Children

SCHIP programs coordinated with the WIC program in 22 states (Table VI.4). WIC provides supplemental food, nutrition education, and health care referrals to low-income women and children up to age five who are determined to be at "nutritional risk." Eligible families either have income below 185 percent of poverty or are already enrolled in Medicaid, TANF, or the Food Stamp Program. Because WIC targets families below 185 percent of poverty, the program covers many of the same children who are eligible (or potentially eligible) for SCHIP.

- Alabama's WIC program assisted in outreach for SCHIP. The WIC staff developed an outreach message and printed it on food vouchers.

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[3] States initially reported that some of their outreach coordination efforts were thwarted by laws designed to prohibit programs from sharing information about potentially eligible children without the consent of their parents. In 2000, the Agricultural Risk Protection Act was passed and signed into law. The legislation amended the National School Lunch Act, to provide states with the flexibility to share information across state and local agencies.

TABLE VI.4

COORDINATION BETWEEN SCHIP AND THE SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS AND CHILDREN (WIC)

State	Program Type	Outreach	Eligibility Determination	Administration	Data Collection	Quality Assurance	Service Delivery	Procurement	Contracting
Total		22	3	4	5	1	1	0	1
Alabama	COMBO	✓							
Alaska[a]	M-SCHIP	✓							
Arizona	S-SCHIP								
Arkansas	M-SCHIP	✓							
California	COMBO								
Colorado	S-SCHIP								
Connecticut	COMBO								
Delaware	S-SCHIP								
District of Columbia	M-SCHIP	✓			✓				
Florida	COMBO								
Georgia	S-SCHIP								
Hawaii	M-SCHIP								
Idaho	M-SCHIP								
Illinois	COMBO	✓							
Indiana	COMBO								
Iowa	COMBO								
Kansas	S-SCHIP	✓							
Kentucky	COMBO								
Louisiana	M-SCHIP	✓	✓						
Maine	COMBO								
Maryland	M-SCHIP	✓							
Massachusetts	COMBO								
Michigan	COMBO	✓							
Minnesota	M-SCHIP	✓							
Mississippi	COMBO								
Missouri	M-SCHIP	✓							
Montana	S-SCHIP								
Nebraska	M-SCHIP	✓							
Nevada	S-SCHIP								
New Hampshire	COMBO	✓			✓	✓			
New Jersey	COMBO	✓	✓		✓				✓
New Mexico	M-SCHIP								
New York	COMBO								
North Carolina	S-SCHIP								
North Dakota	COMBO	✓			✓				
Ohio	M-SCHIP								
Oklahoma	M-SCHIP								
Oregon	S-SCHIP								
Pennsylvania	S-SCHIP								
Rhode Island	M-SCHIP								
South Carolina	M-SCHIP	✓		✓					
South Dakota	COMBO	✓							
Tennessee	M-SCHIP	✓							
Texas	COMBO	✓							
Utah	S-SCHIP								
Vermont	S-SCHIP								
Virginia	S-SCHIP								
Washington	S-SCHIP	✓	✓	✓					
West Virginia	S-SCHIP								
Wisconsin	M-SCHIP	✓		✓	✓		✓		
Wyoming	S-SCHIP	✓		✓					

Source: Mathematica Policy Research analysis of title XXI State Evaluations, Section 3.5 of the State Evaluation Framework.

NOTE: Maine and Oklahoma did not complete this section.

[a] Alaska also provides application assistance and referral assistance.

- Nevada's SCHIP program entered into an inter-agency agreement to obtain names of families who qualified for WIC and who might be eligible for SCHIP. The state provided information to WIC families on the availability of coverage under SCHIP.

C. CONCLUSION

States have made considerable efforts to coordinate their S-SCHIP programs with Medicaid, particularly in the areas of eligibility determination and outreach. Efforts to simplify the application process and to develop joint outreach messages appear to have been successful in boosting traditional Medicaid enrollment and contributed somewhat to recent declines in Medicaid coverage (see Chapter IX). Most states also coordinated the delivery systems and other aspects of program administration (such as contracting, procurement, data collection, and quality assurance) between S-SCHIP and Medicaid.

States were less likely to coordinate their SCHIP programs with MCH, NSLP, and WIC programs. Most coordination took place in the context of outreach and far less in the areas of eligibility determination or program administration. As states continue to search for ways to reach children who are eligible for SCHIP, but who remain uninsured, or become uninsured due to changes in family circumstances, enhanced coordination with other public programs may hold promise for the future.

VII. STATES' REFLECTIONS ON THE EFFECTIVENESS OF THEIR SCHIP OUTREACH EFFORTS

State outreach efforts have been an important factor in raising awareness about enrolling eligible children in SCHIP. Since the implementation of SCHIP, states have placed an emphasis on "reaching out" to eligible children and their families to inform them about Medicaid and SCHIP, answer their questions, and help them enroll in the appropriate program. Evidence about the large proportion of uninsured children who were potentially eligible for Medicaid but not enrolled reinforced the need for effective outreach for SCHIP, as well as Medicaid (Selden et al. 1998). In their evaluations, many states identified the ways in which enrollees heard about the SCHIP program, and they compiled anecdotal information on best practices. A small subset of states has begun evaluating the effectiveness of outreach activities and settings, linking specific outreach efforts to application and enrollment rates.

Title XXI (section 2108(b)(1)(F)) required states to discuss their plans for improving the availability of health insurance for children. Section A of this chapter identifies the methods used by states to assess their outreach efforts, while Section B describes the outreach activities and settings used by states and their perceptions of the effectiveness of these activities and settings. Section C presents the lessons states have learned in building the outreach infrastructure and reaching out to special populations.

A. METHODS USED BY STATES TO ASSESS THEIR OUTREACH EFFORTS

Forty-two states reported in their state evaluations that they had assessed their outreach efforts using one or more approaches. The most common sources of information were enrollment trends, hotline statistics, and application data (Figure VII.1 and Table VII.1). These were the most straightforward data to produce, since, typically, they were supported by automated

FIGURE VII.1

OUTREACH EVALUATION METHODS USED BY STATES

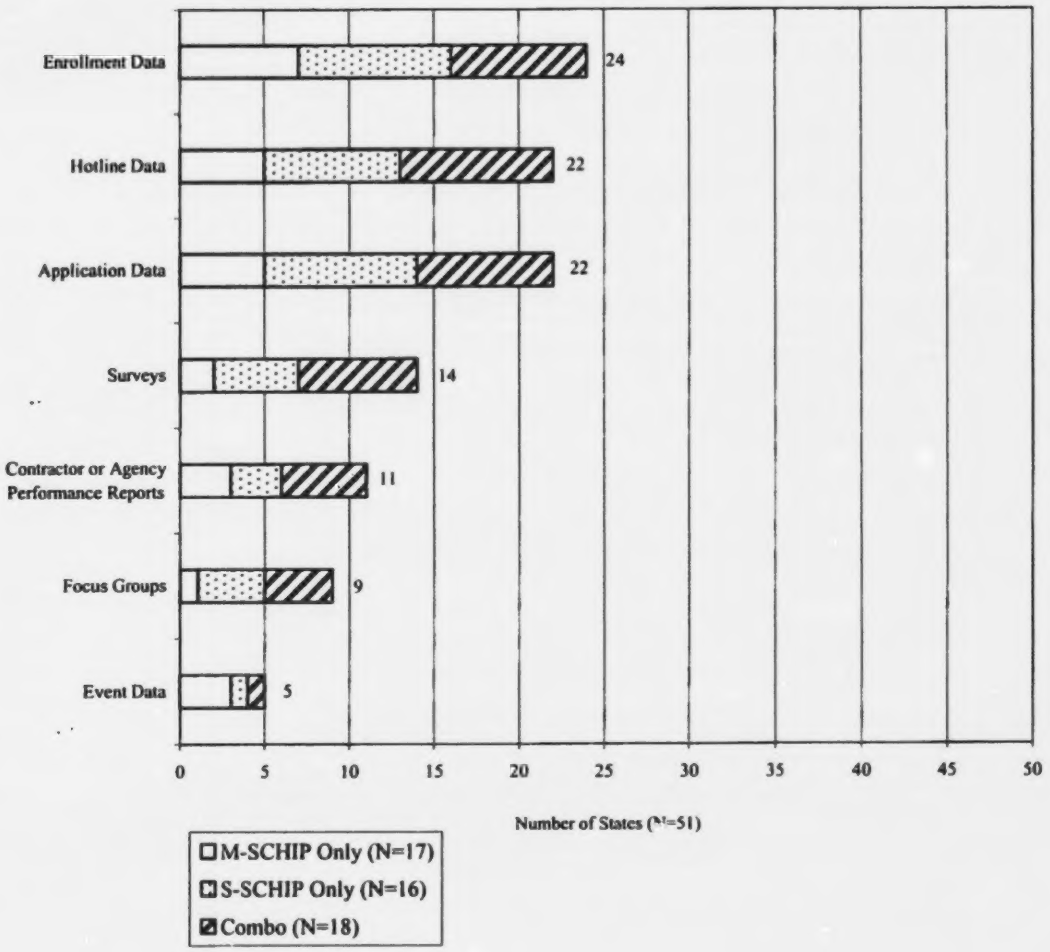

TABLE VII.1

METHODS USED BY STATES TO ASSESS OUTREACH EFFECTIVENESS

State	Program Type	Enrollment Data	Hotline Data	Application Data	Surveys	Contractor or Agency Performance Reports	Focus Groups	Event Data
Total		24	22	22	14	11	9	5
Alabama	COMBO		✓	✓	✓			
Alaska	M-SCHIP	✓			✓			
Arizona	S-SCHIP		✓	✓	✓		✓	
Arkansas	M-SCHIP							
California	COMBO	✓	✓	✓		✓	✓	✓
Colorado	S-SCHIP	✓	✓	✓		✓		
Connecticut	COMBO	✓	✓	✓	✓		✓	
Delaware	S-SCHIP		✓	✓				
District of Columbia	M-SCHIP	✓	✓				✓	✓
Florida	COMBO		✓		✓	✓	✓	
Georgia	S-SCHIP	✓			✓		✓	
Hawaii	M-SCHIP							
Idaho	M-SCHIP	✓	✓					
Illinois	COMBO		✓					
Indiana	COMBO	✓						
Iowa	COMBO	✓				✓		
Kansas	S-SCHIP	✓	✓	✓	NI		NI	
Kentucky	COMBO	✓			✓		✓	
Louisiana	M-SCHIP	✓				✓		
Maine	COMBO				✓			
Maryland	M-SCHIP							
Massachusetts	COMBO	✓			✓	✓		
Michigan	COMBO	✓	✓	✓				
Minnesota	M-SCHIP							
Mississippi	COMBO			✓				
Missouri	M-SCHIP		✓	✓				
Montana	S-SCHIP							
Nebraska	M-SCHIP		✓	✓				✓
Nevada	S-SCHIP	✓		✓		✓		
New Hampshire	COMBO		✓	✓	✓			
New Jersey	COMBO		✓	✓				
New Mexico	M-SCHIP							
New York	COMBO		✓					
North Carolina	S-SCHIP	✓	✓		✓			
North Dakota	COMBO							
Ohio	M-SCHIP	✓		✓	✓			
Oklahoma	M-SCHIP							
Oregon	S-SCHIP			✓				
Pennsylvania	S-SCHIP	✓	✓		✓		✓	
Rhode Island	M-SCHIP	✓						
South Carolina	M-SCHIP			✓				
South Dakota	COMBO	✓						
Tennessee	M-SCHIP					✓		
Texas	COMBO			✓		✓		
Utah	S-SCHIP		✓					
Vermont	S-SCHIP							
Virginia	S-SCHIP	✓	✓				✓	✓
Washington	S-SCHIP	✓		✓		✓		
West Virginia	S-SCHIP	✓		✓	✓			
Wisconsin	M-SCHIP	✓	✓	✓		✓		✓
Wyoming	S-SCHIP			✓				

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations, Section 3.4.3 of the State Evaluation Framework.

NOTE: The type of SCHIP program is as of March 31, 2001. The state evaluations generally present program characteristics as of September 30, 1999.

NI = not implemented.

systems. Other sources were surveys, contractor or agency reports, focus groups, and event data. The most common type of information collected by states was the referral source.[1]

Twenty-four states reported that they monitored their outreach efforts based on enrollment trends, such as tracking weekly or monthly enrollment changes at the county, region, or state level. The majority of states indicated that the objective was to ensure that enrollment was increasing. Iowa and Indiana provided counties with monthly enrollment counts at the state and county level, to measure their progress against their preset enrollment targets. A few states used these data to measure the effects of specific outreach activities on enrollment. For example, California, Nevada, and New Jersey monitored enrollment by event, enrollment site, or organization that provided enrollment assistance to measure the relative success of these events or sites in generating enrollment.

Twenty-two states indicated that they used information from hotlines to monitor outreach. Seven states—California, Connecticut, Delaware, Kansas, New Jersey, New York, and Pennsylvania—reported that they reviewed hotline call volume data, by date, and noted increases in volume that were related to media or school-based campaigns. Pennsylvania and New York decided to increase their hotline staffing during mass-media campaigns as a result of their outreach monitoring efforts.

Twenty-two states reported that they monitored application volume from particular sites, to track the relative effectiveness of particular organizations, events, or established sites, such as provider offices and hospitals. A few states, such as Arizona and Colorado, collected statistics about where applications were distributed and the return rates for each site. California and Delaware paid finders' fees to organizations that provided application assistance, and tracked application volume and incentive payments by organization. Nevada tracked the number of applications and actual enrollments resulting from organization efforts and outreach events.

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[1] Nineteen states reported information on referral sources in their state evaluations. However, the methods and categories are not similar across states. The 19 states reporting are: Alabama, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Louisiana, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, South Dakota, and West Virginia.

Fourteen states conducted phone or mail surveys to evaluate outreach. The majority of surveys targeted new enrollees to learn how they heard about SCHIP; some focused on variations in referral sources among ethnic groups. Massachusetts' enrollee survey gauged the cultural appropriateness of its translated materials. States also surveyed the uninsured (Florida), hotline callers (Pennsylvania), outreach workers (Kentucky), providers (Massachusetts), community-based organizations (North Carolina), and counties (Ohio). North Carolina and Ohio asked respondents to identify which outreach activities were most effective.

Alaska included a survey in its application packet to collect demographic and income data and information on referral sources. The state tracked changes in referral sources as marketing progressed from the Governor's press campaign to program kick-off to local-level outreach. Surveys initially indicated that applicants heard about the program through the media, then through word-of-mouth from friends, family, and neighbors. When the survey showed that an increasing number of applicants were receiving applications from their providers, the state increased training on application assistance to providers, particularly regarding the types of supporting documentation required. The survey data also prompted the state to include a documentation checklist in the application packet.

Eleven states used performance-tracking reports generated by contractors or agencies to monitor outreach. These states delegated outreach and outreach monitoring to a third party, and required their contractors to submit data on application assistance provided (such as number of client contacts) and the number of applications submitted. Performance reports also provided other contextual information about the success of outreach efforts. Florida, for example, required its 26 regional coalitions to submit a quarterly report about individual objectives and performance, including barriers to enrollment, how they were addressed, and whether policy changes were required.

Nine states conducted focus groups of potentially eligible families, community leaders from ethnic communities, and outreach workers, primarily to test marketing materials and messages or to examine the reasons why potentially eligible families did not apply for coverage. Georgia, for example, targeted potentially eligible families, including African-American and Hispanic parents, and used the information to modify messages in the marketing materials for the second year of PeachCare.

Five states monitored the outcome of outreach activities at the event level. These states collected data on application assistance provided, completed applications submitted, and number of people enrolled as a result of each event.

Several states reported that they were working on ways to link enrollment, hotline, and applications data, in order to identify referral and application sources and track whether application requests yielded completed applications and eligible enrollees. These data links could help states develop a comprehensive picture of successful outreach efforts.

- Colorado was working on a new integrated database that would combine all application, hotline, and enrollment information into one consolidated record for each individual. This database will allow its CHP+ program to track not only how many applications have been requested as a result of each outreach strategy, but also how many of those applications resulted in enrollments.
- Pennsylvania performed "geo-mapping" to determine the relationship between enrollment patterns, media advertising, and economic factors, to provide an indication of market penetration for SCHIP. The state also planned to link its hotline data with the central data system, to learn how many callers applied for coverage, the number who were eligible, and how long the application process took.

These methods—combined with anecdotal impressions—provided the basis for some states to assess their effectiveness in conducting outreach. The following section describes states' outreach activities under SCHIP and their perceptions of the effectiveness of their efforts.

B. STATE ASSESSMENTS OF OUTREACH EFFECTIVENESS

1. Types of Outreach Activities Performed by States

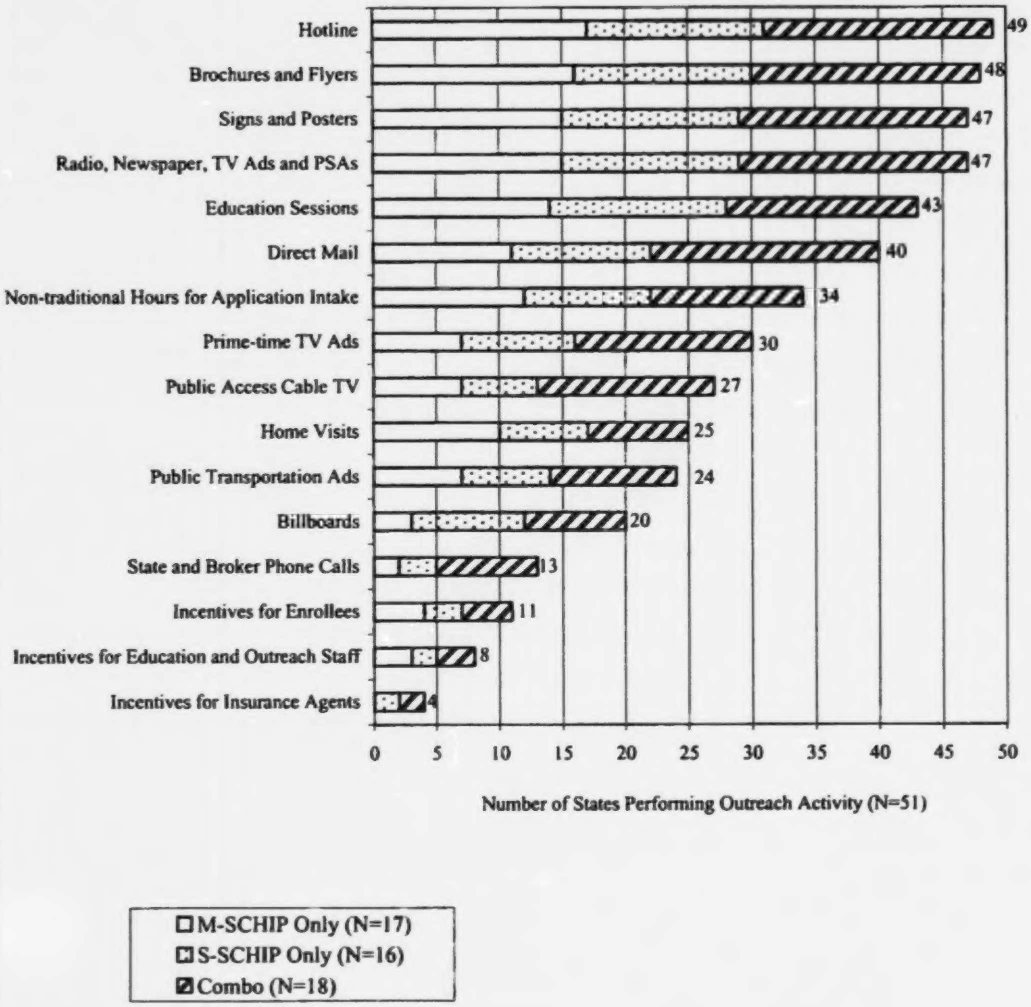
To reach diverse populations, most states combined state-level, mass-media campaigns with local-level, in-person outreach. Mass-media efforts included the use of newspaper, television, and radio ads, direct mail campaigns, brochures/flyers, billboards, and public transportation ads. Local-level outreach activities included in-person efforts, such as education sessions, home visits, and incentives to outreach staff and enrollees.

Outreach activities conducted at the state and local level appeared to be complementary: statewide media advertising built awareness of the program, while local-level outreach provided "points of entry" where families could obtain in-depth program information and receive application assistance. States reported that local-level outreach efforts could tailor statewide media messages to the local community. Pennsylvania noted that families needed to hear messages about available coverage several times—often in several settings—before they applied for SCHIP.

As shown in Figure VII.2, almost all states promoted SCHIP using a hotline, brochures/flyers, radio/television/newspaper ads or public service announcements (PSAs), signs/posters, education sessions, or direct mail. Between one-half and two-thirds of states used nontraditional hours for application intake, prime-time television ads, public access/cable television programming, home visits, or public transportation ads. Fewer than half used billboards (20 states), phone calls by state staff or brokers (13 states), or incentives for enrollees,

FIGURE VII.2

OUTREACH ACTIVITIES PERFORMED BY STATES



education/outreach staff, or insurance agents. Table VII.2 provides a state-by-state list of outreach activities.

Some states reported that they promoted SCHIP by using media similar to those used to promote private health insurance products. In particular, they advertised SCHIP on television and radio and in local newspapers, which are typical commercial marketing outlets. They emphasized the importance of coverage for children, as well as the benefits, provider choice, low cost, and ease of application. Some states designed new logos and catchy marketing messages. Arizona, for example, used the jingle "Because kids will be kids" to suggest that families should not wait until a broken bone, fever, or accident occurs to obtain health insurance. To increase name recognition, most states also gave away such incentive items as Frisbees, magnets, pencils, pens, pins, and T-shirts, with the program name and logo.

During the initial implementation period, some states reported that their marketing messages occasionally required fine-tuning. Nine states reported that they conducted focus groups to test marketing materials and messages or to examine the reasons why potentially eligible families did not apply for coverage.

- In Georgia, focus group results motivated the state to refine the messages in the marketing materials, such as emphasizing PeachCare's comprehensive benefits, low cost, and the broad network of providers that made it likely that families would be able to keep their own provider.
- Pennsylvania reported that free or low-cost health insurance was not necessarily perceived as positive in rural communities, which tended to equate this message with government dependency. Instead, the state began to stress the importance of having insurance coverage and added new, health-related messages.

Some states reported a mixed experience in co-marketing Medicaid and SCHIP programs. California found that the joint campaign and logo may have helped improve Medi-Cal's image at

TABLE VII.2

TYPES OF SCHIP OUTREACH ACTIVITIES PERFORMED BY STATES

		In-Person and Individualized Outreach Activities							
State	Program Type	Hotline	Education Sessions	Non-Traditional Hours for Application Intake	Home Visits	State and Broker Phone Calls	Incentives for Enrollees	Incentives for Education and Outreach Staff	Incentives for Insurance Agents
Total		49	43	34	25	13	11	8	4
Alabama	COMBO	✓	✓	✓					
Alaska	M-SCHIP	✓	✓	✓	✓				
Arizona	S-SCHIP	✓	✓		✓		✓		
Arkansas	M-SCHIP	✓							
California	COMBO	✓	✓			✓		✓	✓
Colorado	S-SCHIP	✓		✓	✓				
Connecticut	COMBO	✓		✓		✓			
Delaware	S-SCHIP	✓	✓			✓			
District of Columbia	M-SCHIP	✓	✓	✓	✓	✓			
Florida	COMBO	✓	✓	✓	✓	✓			
Georgia	S-SCHIP	✓	✓	✓	✓				
Hawaii	M-SCHIP	✓							
Idaho	M-SCHIP	✓	✓	✓					
Illinois	COMBO	✓	✓					✓	✓
Indiana	COMBO	✓	✓	✓	✓		✓		
Iowa	COMBO	✓	✓	✓	✓	✓			
Kansas	S-SCHIP	✓	✓	✓					
Kentucky	COMBO	✓	✓	✓	✓	✓	✓		
Louisiana	M-SCHIP	✓	✓						
Maine	COMBO	✓			✓				
Maryland	M-SCHIP	✓	✓		✓				
Massachusetts	COMBO	✓	✓	✓		✓			
Michigan	COMBO	✓	✓	✓	✓	✓	✓		
Minnesota	M-SCHIP	✓	✓	✓	✓	✓	✓		
Mississippi	COMBO	✓	✓	✓					
Missouri	M-SCHIP	✓	✓	✓	✓		✓		
Montana	S-SCHIP		✓						
Nebraska	M-SCHIP	✓	✓		✓				
Nevada	S-SCHIP	✓	✓	✓					
New Hampshire	COMBO	✓							
New Jersey	COMBO	✓	✓	✓	✓	✓	✓		
New Mexico	M-SCHIP	✓	✓	✓			✓	✓	
New York	COMBO	✓	✓	✓					
North Carolina	S-SCHIP	✓	✓	✓	✓	✓	✓		✓
North Dakota	COMBO	✓	✓		✓				
Ohio	M-SCHIP	✓	✓	✓	✓			✓	
Oklahoma	M-SCHIP	✓	✓	✓	✓				
Oregon	S-SCHIP	✓	✓	✓					
Pennsylvania	S-SCHIP	✓	✓	✓	✓			✓	
Rhode Island	M-SCHIP	✓	✓	✓				✓	
South Carolina	M-SCHIP	✓		✓	✓		✓		
South Dakota	COMBO	✓	✓						
Tennessee	M-SCHIP	✓	✓	✓	✓				
Texas	COMBO	✓	✓	✓				✓	
Utah	S-SCHIP	✓	✓						
Vermont	S-SCHIP	✓	✓	✓	✓				
Virginia	S-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓
Washington	S-SCHIP								
West Virginia	S-SCHIP	✓	✓	✓					
Wisconsin	M-SCHIP	✓	✓	✓					
Wyoming	S-SCHIP	✓	✓						

TABLE VII.2 *(continued)*

	Mass Media and Mass Marketing Outreach Activities							
State	Brochures and Flyers	Radio, Newspaper, TV Ads, and PSAs	Signs and Posters	Direct Mail	Prime Time TV Ads	Public Access Cable TV	Public Transportation Ads	Billboards
Total	48	47	47	40	30	27	24	20
Alabama	✓	✓	✓	✓	✓	✓		
Alaska	✓	✓	✓			✓		
Arizona	✓	✓	✓	✓	✓			✓
Arkansas				✓	✓			
California	✓	✓	✓	✓	✓	✓	✓	✓
Colorado	✓	✓	✓		✓		✓	✓
Connecticut	✓	✓	✓	✓		✓		✓
Delaware	✓	✓	✓	✓	✓	✓	✓	✓
District of Columbia	✓	✓	✓	✓		✓	✓	
Florida	✓	✓	✓	✓	✓	✓	✓	✓
Georgia	✓	✓	✓		✓		✓	✓
Hawaii	✓	✓	✓		✓	✓	✓	
Idaho	✓	✓	✓		✓			
Illinois	✓	✓	✓	✓	✓	✓	✓	
Indiana	✓	✓	✓	✓	✓	✓	✓	✓
Iowa	✓	✓	✓	✓	✓		✓	
Kansas	✓	✓	✓	✓	✓	✓	✓	✓
Kentucky	✓	✓	✓	✓	✓	✓	✓	✓
Louisiana	✓	✓	✓					
Maine	✓	✓	✓	✓	✓	✓		
Maryland	✓	✓	✓			✓	✓	✓
Massachusetts	✓	✓	✓	✓	✓	✓	✓	
Michigan	✓	✓	✓	✓	✓	✓	✓	✓
Minnesota	✓	✓	✓	✓		✓		
Mississippi	✓	✓	✓	✓				
Missouri	✓	✓	✓	✓			✓	✓
Montana		✓		✓				
Nebraska	✓	✓	✓	✓				
Nevada	✓	✓	✓	✓		✓		
New Hampshire	✓	✓	✓	✓	✓			
New Jersey	✓	✓	✓	✓	✓	✓	✓	✓
New Mexico	✓	✓	✓	✓	✓			
New York	✓	✓	✓	✓	✓	✓	✓	✓
North Carolina	✓	✓	✓	✓	✓	✓		✓
North Dakota	✓	✓	✓	✓				
Ohio	✓	✓	✓	✓	✓	✓	✓	✓
Oklahoma	✓	✓	✓	✓				
Oregon	✓		✓					
Pennsylvania	✓	✓	✓	✓	✓	✓	✓	✓
Rhode Island	✓			✓				
South Carolina	✓	✓	✓	✓	✓		✓	
South Dakota	✓	✓	✓	✓		✓		
Tennessee	✓	✓	✓					
Texas	✓	✓	✓	✓	✓	✓		
Utah	✓	✓	✓	✓	✓		✓	✓
Vermont	✓	✓	✓	✓				
Virginia	✓	✓	✓	✓	✓	✓	✓	✓
Washington								
West Virginia	✓	✓	✓	✓				
Wisconsin	✓	✓	✓	✓	✓	✓	✓	
Wyoming	✓	✓	✓					

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations, Section 3.4.1 of the State Evaluation Framework.

NOTE: The type of SCHIP program is as of March 31, 2001. The state evaluations generally present program characteristics as of September 30, 1999.

the expense of the SCHIP Healthy Families enrollment. On the other hand, Connecticut, Massachusetts, and New Jersey each promoted their combination programs as one program and noted that this made marketing and outreach much simpler.

At the local level, most states indicated that they partnered with community-based organizations, providers, and other organizations to conduct in-person outreach. The majority of states reported that in-person outreach by trusted community members was important in increasing awareness and building trust in new programs—particularly in minority communities where past experience with government programs may be negative. Some states reported that enrollment assistance also was an important component of local outreach because families benefited from an explanation of the program and assistance in completing the application.

Even with simplified, mail-in enrollment forms, Illinois, Iowa, Massachusetts, New York, and Texas reported that local outreach was essential to ensure that applications were completed correctly and that they were actually submitted.

- Massachusetts found that outreach strategies tailored to the target communities were successful. One contractor reported that, in rural Massachusetts, male heads of households tended to determine whether families applied for MassHealth benefits. To attract this group, the contractor assembled a toolbox with donations by area businesses to be raffled off. The toolbox was brought to popular community meeting spots and events targeted toward men, resulting in significant increases in the number of applications.
- New York found that mass-media approaches still did not reach some populations. The state hired community-based enrollment assistants to provide outreach and application assistance to hard-to-reach groups. New York also found that assistance by phone was helpful for families in need of additional information and help with applications.
- Texas found that consumers had many questions that they wanted answered before applying and that trusted individuals from their communities were one of the best sources of program information, particularly in minority communities where distrust of government was high.

As part of their state evaluations, states rated the effectiveness of their outreach activities on a five-point scale, where 1 is least effective and 5 is most effective. As shown in Table VII.3, hotlines, home visits, and brochures/flyers were rated most effective, averaging four points or more. Radio, newspaper, and television ads/PSAs, education sessions, incentives for enrollees, and incentives for insurance agents rated between 3.5 and 3.9 points. These types of outreach activities are a mix of mass-media and in-person outreach methods.

The importance of in-person outreach was evident in the rating of home visits; although only 25 states conducted home visits, this activity was one of three that averaged a score of four or higher. Similarly, education sessions also were highly rated, because these activities enabled families to ask questions about the program and obtain application assistance.

States perceived direct mail, incentives for education/outreach staff, signs and posters, public transportation ads, and billboards as somewhat less effective, rating these, on average, as 3.4 or lower (Table VII.3). These activities tend to be mass-outreach methods designed primarily to raise awareness of the program and encourage families to request applications, but they may not lead to an increase in application requests, application submissions, or enrollment.

Direct mail, a classic mass marketing strategy, yielded poor results for several states. Arizona, for example, reported that an expensive direct mail campaign yielded a response rate of 2 percent. California's targeted mailing to families on its Medicaid share-of-cost program resulted in few application requests. New Jersey experienced a 3 percent response rate to reminder post cards that were sent to families who requested applications but did not submit them. The state hoped to improve the response rate by using phone calls to follow up after reminder cards were sent.

There were some differences across program types in the outreach activities used. Combination states were more active in using mass-media outreach approaches, compared to

TABLE VII.3

STATE RATINGS OF THE EFFECTIVENESS OF THEIR SCHIP OUTREACH ACTIVITIES

		Number of States Conducting Activity[1]			
Outreach Activity	Effectiveness Rating (1-5 Scale)	Total (N=51)	M-SCHIP Only (N = 17)	S-SCHIP Only (N = 16)	COMBO (N=18)
Hotline	4.3	49	17	14	18
Home Visits	4.2	25	10	7	8
Brochures/Flyers	4.1	48	16	14	18
Prime-Time TV Ads	3.9	30	7	9	14
Education Sessions	3.8	43	14	14	15
Incentives for Enrollees	3.7	11	4	3	4
Radio/Newspaper/TV Ads/PSAs	3.7	47	15	14	18
Non-Traditional Hours for Application Intake	3.6	34	12	10	12
Public Access Cable TV	3.6	27	7	6	14
Incentives for Insurance Agents	3.5	4	0	2	2
State and Broker Phone Calls	3.5	13	2	3	8
Direct Mail	3.4	40	11	11	18
Incentives for Education and Outreach Staff	3.4	8	3	2	3
Signs and Posters	3.4	47	15	14	18
Public Transportation Ads	3.1	24	7	7	10
Billboards	2.9	20	3	9	8

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations, Section 3.4.1 of the State Evaluation Framework.

NOTE: The type of SCHIP program is as of March 31, 2001. The state evaluations generally present program characteristics as of September 30, 1999. Effectiveness rating based on a 1-5 scale, where 1=least effective, 5=most effective.

[1] Totals may slightly overstate number of states that rated this activity. Not all states that conducted an outreach activity reported a rating.

M-SCHIP-only and S-SCHIP-only states. As shown in Table VII.3, a larger number of combination states used direct mail, radio/newspaper/television ads/PSAs, prime time television ads, and public access television programming, compared to states with only M-SCHIP or S-SCHIP programs.

2. Types of Outreach Settings Used by States

States conducted outreach in a variety of locations where low-income and working families or their children were likely to be found. As shown in Figure VII.3 and Table VII.4, most states conducted outreach in community health centers, public meetings/health fairs, community-sponsored events, schools/adult education sites, provider locations, social service agencies, day care centers, or faith-based organizations. A majority of states also used libraries, grocery stores, public housing, job training centers, homeless shelters, workplaces, fast food restaurants, or laundromats. Fewer than half the states reported using refugee resettlement programs or senior centers as outreach sites for SCHIP. Some states reported conducting outreach in other types of settings, including the following:

- The District of Columbia conducted outreach in service sector business sites where workers were less likely to have health insurance, such as temporary employment agencies, taxi companies, barbershops, construction companies, hotels, recreation centers, convenience stores, and parking garages.
- Kansas conducted outreach in beauty shops, restaurants, chain and local retail shops, and community swimming pools. In more rural areas, Kansas conducted outreach at state and county fairs, as well as at farmers' cooperatives.

As shown in Table VII.5, the most highly rated outreach settings were provider locations, community health centers, schools or adult education centers, homes of potentially eligible families, and social service agencies; they were rated four or slightly more. Two factors appear

FIGURE VII.3

OUTREACH SETTINGS USED BY STATES

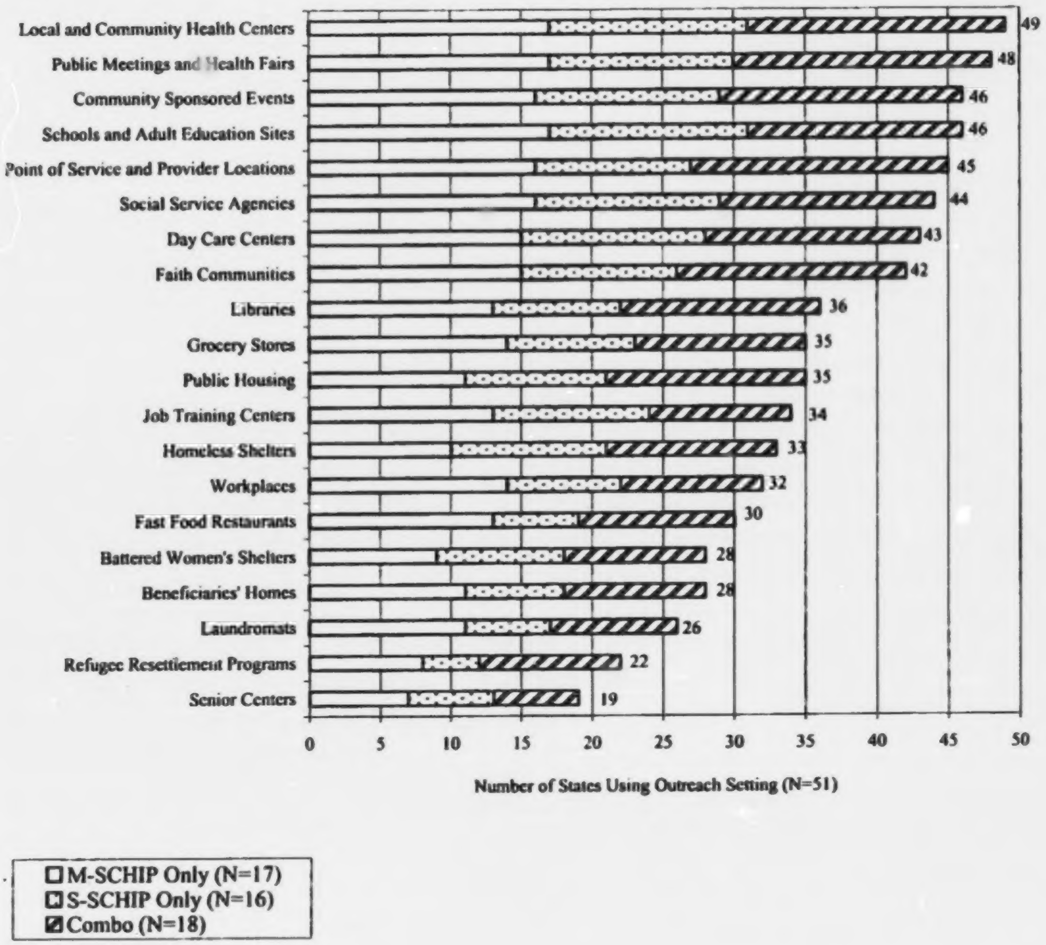


TABLE VII.4

TYPES OF OUTREACH SETTINGS USED BY STATES

State	Program Type	Local and Community Health Centers	Public Meetings and Health Fairs	Community Sponsored Events	Schools and Adult Education Sites	Point of Service and Provider Locations	Social Service Agency	Day Care Centers	Faith Communities	Libraries	Grocery Stores
Total		49	48	46	46	45	44	43	42	36	35
Alabama	COMBO	✓	✓	✓	✓	✓	✓	✓	✓		
Alaska	M-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Arizona	S-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓		✓
Arkansas	M-SCHIP	✓	✓		✓	✓		✓			
California	COMBO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Colorado	S-SCHIP	✓	✓	✓	✓	✓	✓	✓			
Connecticut	COMBO	✓	✓	✓		✓		✓	✓	✓	✓
Delaware	S-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓		✓
District of Columbia	M-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Florida	COMBO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Georgia	S-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Hawaii	M-SCHIP	✓	✓	✓	✓	✓	✓				
Idaho	M-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Illinois	COMBO	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Indiana	COMBO	✓	✓	✓	✓	✓	✓	✓	✓		✓
Iowa	COMBO	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Kansas	S-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kentucky	COMBO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Louisiana	M-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maine	COMBO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maryland	M-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Massachusetts	COMBO	✓	✓	✓	✓	✓				✓	
Michigan	COMBO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minnesota	M-SCHIP	✓	✓	✓	✓	✓	✓		✓	✓	✓
Mississippi	COMBO	✓	✓	✓	✓	✓	✓	✓	✓		
Missouri	M-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Montana	S-SCHIP										
Nebraska	M-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓		✓
Nevada	S-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓	✓	
New Hampshire	COMBO	✓	✓	✓	✓	✓	✓	✓		✓	✓
New Jersey	COMBO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
New Mexico	M-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
New York	COMBO	✓	✓	✓		✓		✓	✓		✓
North Carolina	S-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
North Dakota	COMBO	✓	✓			✓	✓		✓	✓	✓
Ohio	M-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Oklahoma	M-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Oregon	S-SCHIP	✓			✓		✓				
Pennsylvania	S-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rhode Island	M-SCHIP	✓	✓	✓	✓		✓	✓	✓		
South Carolina	M-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
South Dakota	COMBO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tennessee	M-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Texas	COMBO	✓	✓	✓	✓	✓	✓		✓	✓	
Utah	S-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓		✓
Vermont	S-SCHIP	✓	✓	✓	✓		✓	✓		✓	✓
Virginia	S-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Washington	S-SCHIP										
West Virginia	COMBO	✓	✓	✓	✓	✓		✓	✓	✓	✓
Wisconsin	M-SCHIP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Wyoming	S-SCHIP	✓	✓	✓	✓		✓	✓	✓	✓	

TABLE VII.4 *(continued)*

State	Public Housing	Job Training Centers	Homeless Shelters	Workplaces	Fast Food Restaurants	Battered Women's Shelters	Applicants' Homes	Laundromats	Refugee Resettlement Programs	Senior Centers
Total	35	34	33	32	30	28	28	26	22	19
Alabama	✓		✓			✓				✓
Alaska	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Arizona		✓	✓		✓	✓	✓			
Arkansas					✓					
California	✓	✓	✓	✓			✓	✓		
Colorado			✓				✓			
Connecticut	✓	✓			✓	✓		✓		
Delaware	✓	✓	✓	✓		✓				✓
District of Columbia	✓	✓	✓	✓	✓	✓				✓
Florida	✓	✓	✓		✓		✓	✓	✓	
Georgia	✓	✓	✓	✓						
Hawaii	✓			✓					✓	
Idaho		✓	✓	✓		✓		✓		
Illinois				✓					✓	
Indiana	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Iowa	✓	✓		✓	✓	✓	✓		✓	
Kansas	✓	✓	✓	✓	✓	✓	✓	✓		✓
Kentucky	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Louisiana	✓	✓	✓	✓	✓			✓		✓
Maine	✓	✓	✓	✓			✓			
Maryland	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Massachusetts	✓		✓	✓	✓	✓			✓	
Michigan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minnesota		✓		✓			✓	✓	✓	
Mississippi			✓		✓					
Missouri	✓	✓	✓	✓	✓	✓	✓	✓		
Montana										
Nebraska	✓				✓		✓			
Nevada	✓	✓	✓	✓		✓		✓		
New Hampshire										
New Jersey	✓	✓	✓	✓	✓	✓	✓	✓		✓
New Mexico		✓	✓	✓	✓	✓	✓	✓	✓	✓
New York	✓				✓		✓	✓		
North Carolina	✓	✓	✓	✓	✓	✓	✓	✓		
North Dakota	✓		✓			✓			✓	✓
Ohio		✓		✓	✓		✓	✓		
Oklahoma	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Oregon										
Pennsylvania	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rhode Island		✓		✓			✓	✓		
South Carolina	✓	✓			✓		✓	✓		
South Dakota	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tennessee	✓		✓	✓	✓	✓			✓	
Texas									✓	
Utah	✓	✓				✓			✓	
Vermont		✓	✓	✓		✓	✓	✓	✓	✓
Virginia	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Washington										
West Virginia	✓	✓			✓					✓
Wisconsin	✓	✓	✓	✓	✓	✓	✓		✓	✓
Wyoming	✓		✓							

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations, Section 3.4.2 of the State Evaluation Framework.

NOTE: The type of SCHIP program is as of March 31, 2001. The state evaluations generally present program characteristics as of September 30, 1999.

TABLE VII.5

STATE RATINGS OF THE EFFECTIVENESS OF THEIR SCHIP OUTREACH SETTINGS

		Number of States Using Outreach Setting[a]			
Outreach Setting	Effectivness Rating (1-5 Scale)	Total (N=51)	M-SCHIP Only (N=17)	S-SCHIP Only (N=16)	COMBO (N=18)
Local and Community Health Centers	4.3	49	17	14	18
Point of Service and Provider Locations	4.3	45	16	11	18
Schools and Adult Education Sites	4.2	46	17	14	15
Applicants' Homes	4.1	28	11	7	10
Social Service Agencies	4.0	44	16	13	15
Community Sponsored Events	3.7	46	16	13	17
Job Training Centers	3.4	34	13	11	10
Public Meetings and Health Fairs	3.4	48	17	13	18
Refugee Resettlement Programs	3.3	22	8	4	10
Day Care Centers	3.2	43	15	13	15
Faith Communities	3.2	42	15	11	16
Homeless Shelters	3.2	33	10	11	12
Workplaces	3.2	32	14	8	10
Public Housing	3.1	35	11	10	14
Fast Food Restaurants	2.8	30	13	6	11
Senior Centers	2.8	19	7	6	6
Battered Women's Shelters	2.7	28	9	9	10
Grocery Stores	2.7	35	14	9	12
Libraries	2.7	36	13	9	14
Laundromats	2.4	26	11	6	9

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations, Section 3.4.2 of the State Evaluation Framework.

NOTE: The type of SCHIP program is as of March 31, 2001. The state evaluations generally present program characteristics as of September 30, 1999. Effectiveness rating based on a 1-5 scale, where 1=least effective, 5=most effective.

[a] Totals may slightly overstate the number of states that rated this setting. Not all states that used an outreach setting reported a rating.

to be associated with state perceptions of the effectiveness of particular settings: the salience, or relevance, of health insurance to a particular setting, as well as the opportunity for families to obtain in-person information and application assistance in that setting.

States reported that providers and social service agencies were viewed as effective settings for outreach, since lack of health insurance can be a barrier for families seeking to obtain medical care. The majority of states targeted these sites to provide program information and assistance with SCHIP application forms because their staff had daily interaction with potentially eligible SCHIP children and their families. States indicated that schools were also an important outreach setting for SCHIP, not only because they were the best source of the target population, but also because they often required proof of immunization as a condition of enrollment, or physicals for participation in athletics. As a result, families seem to be receptive to learning about SCHIP through schools.

- South Carolina used a mail-in application distributed through the public school system, health providers, churches, day care centers, and community organizations. Distribution through the public schools was so successful that it eliminated the need for more formal public information campaigns, including paid advertising.
- Only a few states explicitly reported using a check-off box on the Free/Reduced Lunch Program application. Kentucky and New Jersey found this to be a good source of application requests. Rhode Island, however, reported that most of the families requesting applications were already enrolled in RIteCare.

As shown in Table VII.5, nine settings rated between 3.0 and 3.7: community-sponsored events, job training centers, public meetings/health fairs, refugee resettlement programs, day care centers, faith-based communities, homeless shelters, workplace, and public housing. A few states reported that health fairs and other community events were appropriate for raising awareness about SCHIP but not for providing application assistance because families needed more privacy and individual assistance.

Settings that rated between 2.0 and 2.9 were sites where health insurance for children would be the least relevant: senior centers, fast food restaurants, libraries, grocery stores, battered women's shelters, and laundromats.

There were slight differences across program types in the outreach settings (Table VII.5). Compared to M-SCHIP and combination states, S-SCHIP states were somewhat less likely to conduct outreach in applicants' homes (7 states), refugee resettlement programs (4 states), and workplaces (8 states).

C. LESSONS LEARNED IN BUILDING THE OUTREACH INFRASTRUCTURE

States have spent considerable effort building the outreach infrastructure for their SCHIP programs. The state evaluations offered insights into the lessons that states learned in (1) building capacity for conducting outreach activities; (2) coordinating outreach activities; (3) training state and local partners; and (4) financing outreach under SCHIP.

1. Building Capacity for Outreach Activities

To conduct outreach for SCHIP, states created or enhanced outreach partnerships with Federal, state, and community programs and organizations that served the new SCHIP-eligible target population. Typically, states worked with Federal agencies and programs, such as the National School Lunch Program (NSLP) and the Special Supplemental Food Program for Women, Infants, and Children (WIC); other state agencies, such as public health and education; providers; community-based organizations, including churches and tribal organizations; and grantees funded by the Robert Wood Johnson Foundation (RWJF) "Covering Kids" initiative. States said that partnerships with public and private organizations facilitated outreach to a wide audience through a variety of in-person and mass-outreach techniques.

- Illinois used a multi-faceted outreach approach that included expanding the types of providers that could serve as KidCare Application Agents (KCAAs); offering $50 technical assistance payments to KCAAs; developing colorful and vivid promotional materials; setting up an all-purpose toll-free KidCare hotline; collaborating with the RWJF Covering Kids Illinois Coalition; broadcasting radio and television ads; and posting bus and train advertisements. The state provided $1.6 million in funding to 29 organizations for specialized outreach to African Americans, Hispanics, immigrants, non-English-speaking populations, and rural communities. The state also encouraged outreach by employers, schools, faith-based organizations, and health care providers.

- New Jersey created lists of potentially eligible families for direct mailings, based on the Electronic Registry of Births or hospital records of families that used charity care. New Jersey also targeted potentially eligible families through notices enclosed with state employee payment stubs, utility bills, and Department of Motor Vehicle renewal notices, and brochures distributed through public schools. New Jersey also partnered with community and faith-based groups to conduct in-person outreach and worked with Wal-Mart stores and the Martha Stewart home brand to promote SCHIP.

- Virginia received an RWJF Covering Kids grant that supported three pilot outreach programs: a faith-based pilot in a metropolitan area comprised of seven cities; a rural medical center covering three counties; and an inner-city medical center for low-income families. Each program collaborated with other community-based organizations to recruit and train volunteers as outreach workers, and participated in community events to market and promote SCHIP enrollment. To simplify the application and enrollment process, the pilot programs were testing an electronic application.

2. Coordinating Outreach Activities

State and local outreach efforts required a certain degree of centralization and extensive coordination, according to states, to ensure consistency in marketing and enrollment assistance. Eight states—Alabama, Arizona, Florida, Iowa, Kentucky, Louisiana, Maryland, and Montana—reported that they used state-level work groups or task forces with a broad array of stakeholders to develop a unified approach to outreach. Other states—including Alaska, Massachusetts, New Hampshire, South Dakota, and Wisconsin—chose to coordinate at the state level using internal staff. The following examples illustrate the range and complexity of coordination efforts that states pursued:

- Alabama used a broad work group to research issues and make recommendations on how the state could best develop services for uninsured children. When implementation of Phase II began, the state distributed program information at the local level, using the SCHIP work group partners. Local agencies, advocacy groups, and associations arranged forum meetings and mailings to send information to their constituencies. The primary outreach tool was a detailed information brochure to accompany the application, along with a stamped, self-addressed envelope. Combining local level outreach with widespread public service announcements and press conferences resulted in ALL Kids receiving applications on approximately 90,000 children in the first year of the program.

- Alaska hired an experienced outreach coordinator to plan and implement strategic marketing campaigns at the state and local level, including producing professional marketing materials and overseeing a staff of five regionally based outreach specialists. The state-level outreach coordinator worked with the Governor's Office to coordinate press conferences for Denali KidCare and worked with the state Medicaid agency to develop a simplified application form, attractive marketing and promotional materials, and a user-friendly Denali KidCare website. At the local level, outreach specialists cultivated and trained a statewide network of more than 1,000 voluntary "access points"—providers, community-based organizations, and social service agencies—that were willing to distribute information and applications to the public.

- Iowa coordinated outreach with grassroots community leaders through the Iowa Communication Network, outreach conference calls, and annual conferences. The state's annual outreach conferences provided a forum for training and strategic outreach planning, and an opportunity for attendees to share best practices for enrolling potentially eligible children. Iowa held its first outreach conference in Des Moines for 450 attendees, which included community action agencies, public health agencies, schools, state health employees, and providers in July 1999.

Many states found coordination of outreach efforts to be a formidable task. Kansas reported that coordination among Federal agencies, national organizations, and state entities required ongoing communication and definition of responsibilities, particularly because the RWJF Covering Kids initiative and the state-funded outreach contractor overlapped in their outreach approaches. To avoid confusion, the state developed a single marketing message.

Several states reported that they encountered difficulties when they did not invest the time and resources needed for coordination. Ohio found that allocating funding for outreach to the county level, without communicating clear guidance on how the money was to be used, led several counties to market the M-SCHIP program under county-specific names. This weakened the momentum for building awareness for a single program and led to consumer and provider confusion when they received conflicting state and county program materials. Subsequently, Ohio developed a statewide marketing strategy with input from its medical care and children's outreach advisory committees.

3. Training State and Local Partners

States indicated that they increased "enrollment opportunities" for families by training state and local partners to perform outreach and enrollment assistance. Most states reported that they partnered with providers, schools, and community-based organizations (CBOs) to conduct outreach and provide application assistance. Decentralizing outreach and application assistance to the local level raised the likelihood that families would apply, by increasing the number of places where they could obtain information and application assistance. States noted that the effectiveness of local partners was enhanced by other efforts to simplify the application process, such as the use of shorter, mail-in forms.

The role of CBOs varied from simply distributing information to providing one-on-one enrollment assistance. Several states noted that structured training of CBOs and others providing enrollment assistance was important to their success in enrolling children in SCHIP. Alaska reported that tailored, hands-on training was essential to ensuring the effectiveness of application assistance provided by rural community organizations, and American Indian tribal organizations. California also emphasized the importance of directing resources to training CBO partners.

In using nongovernmental organizations and schools to promote SCHIP, states said that they tapped into the trust families already had for these organizations, thereby avoiding the stigma associated with going to the local welfare office to apply. In some cases, the advent of mail-in applications and use of other organizations for enrollment had a spillover effect: Indiana reported that its Medicaid offices found families' concerns about stigma for the program diminished over time.

Several states indicated that the "outstationing" of outreach workers was key. Indiana noted that hospitals and health centers were particularly active in enrollment. Wisconsin reported that its 70 outstationed sites contributed to better customer service, as well as to BadgerCare enrollment growth. The majority of Wisconsin's outstationed sites had personal computers with dial-up, real-time capability to connect to the application processing system and the capability to enter an application from an applicant's home. Between June and September 1999, 60 outstationed sites processed approximately 3,300 applications, took 4,300 applicant appointments, and fielded 11,100 program inquiries.

4. Financing Outreach Activities

A few states reported that the 10 percent cap on administrative expenses required them to be creative in funding outreach activities under title XXI. In addition, several states reported foregone opportunities to conduct outreach in order to stay within the 10 percent administrative cap.

- Georgia noted that the greatest challenge in implementing an effective outreach program was the cap on Federal matching of administrative expenses. Georgia reported that, despite "overwhelming enthusiasm" by advocates, community groups, and individuals willing to promote PeachCare for Kids, the state was limited in the number of outreach materials it could produce.
- North Carolina stated that it limited outreach to community-based efforts rather than using mass-media approaches, and relied on its existing infrastructure rather than creating new positions.
- Utah reported that innovative approaches to reach various populations were rejected because of cost constraints imposed by the cap, and instead the state could afford only "the most basic and tested outreach activities."

Some states reported that they found other ways to fund outreach:

- Alabama relied on state and provider organizations to disseminate information, while setting aside program funds for brochure design and application processing.
- Illinois spent state dollars—especially in the early stages of SCHIP implementation—to aggressively implement its outreach strategy.
- Kentucky used an RWJF Covering Kids grant to the University of Kentucky to promote collaboration and innovation statewide, while funds from welfare reform enabled the state to simplify Medicaid eligibility systems and conduct joint outreach.
- New York relied on health plans to publish materials in the languages of their target populations because the state could afford only to print limited quantities of materials in other languages.
- West Virginia obtained grants from multiple sources to support the efforts of nine outreach workers stationed around the state.

D. LESSONS LEARNED ABOUT OUTREACH TO SPECIAL POPULATIONS

States reported developing special outreach strategies to reach populations such as ethnic minorities, immigrants, religious groups, and rural communities. Many states devised culturally sensitive promotional images and, when appropriate, language-specific advertising to market the program in newspapers and on radio and television stations popular among the target populations. Many states also partnered with CBOs that worked with particular populations, to build awareness and trust for their program through in-person outreach.

States that translated materials and applications into other languages most often chose Spanish, followed by other languages or dialects commonly found throughout the state or in particular regions, such as Creole (Louisiana and Florida) and Cantonese (California). Some states, such as New York, had such linguistic diversity that they could print only limited quantities of promotional materials in other languages (such as Chinese, Hebrew, Hindi, Russian, and Korean) due to cost.

Other examples of state approaches to promote SCHIP to special populations include:

- Arizona marketed to Hispanic families by advertising the KidCare logo on the side of "*paletas*," the carts ice cream vendors push through Spanish-speaking neighborhoods during the summer, and training the vendors about the program. This effort received considerable newspaper and television coverage. Arizona also used a roving Kid-Care van staffed with bilingual program representatives. The van went to communities as part of health fairs and other events to promote KidCare, and staff went to remote Native American reservations to attend tribal events.
- Massachusetts developed and disseminated MassHealth program information in the "*photonovela*" style popular among the Spanish-speaking population.

Several states indicated that in-person outreach by trusted, bilingual community-based outreach workers worked best in building awareness, knowledge, and trust among limited English-speaking populations about new programs:

- Arizona and Texas reported that door-to-door canvassing and home visits by "*promotores*" worked well among rural Hispanic communities, particularly those on the southern border in Arizona. *Promotores* are lay health workers who work at local health clinics and are members of the local community. *Promotores* conducted home visits, provided health information and referrals, and assisted with applications. However, Arizona noted that this approach did not work well in urban areas, presumably because families were not as familiar with the workers from the local health clinic.
- Rhode Island reported that its community-based staff of 16 bilingual outreach workers was very effective in reaching the state's non-English-speaking Cambodian, Hispanic, Laotian, and Portuguese populations. Outreach workers found that word-of-mouth referrals from other agency programs (such as English-as-a-Second-Language and child care programs), and door-to-door outreach were most effective in identifying and enrolling low-income children.

States reported that marketing via language-specific, paid advertising and PSAs was successful in generating hotline calls. Louisiana promoted its LaCHIP program through local radio and television talk-show hosts. Arizona found that many Hispanic callers had heard about the program from PSAs on Radio Campesina. Rhode Island reported an 18 percent increase in calls to its Spanish Info Line during a six-month radio campaign on a local Spanish-language radio station.

Several states reported that the effectiveness of outreach media differed among populations:

- Florida found that television and families/friends were important referral sources for African-American and Hispanic families, whereas newspapers or social service agencies were more important referral sources for white families.
- Georgia found that PeachCare advertisements were quite successful in reaching African-American and white families and that families, friends, and churches were most successful in reaching Hispanic families.

Mass media did not reach all groups successfully, according to states. Georgia reported that issues of trust, cultural variances, immigration status, language differences, and illiteracy were the most common reasons that traditional outreach approaches did not reach nonparticipating families. New York reported "large pockets of unserved and hard-to-reach communities" that did not have access or exposure to traditional outreach media—such as mainstream newspaper and radio marketing—due to religious strictures or literacy barriers within their own linguistic group. New York developed strategies to reach these groups, including the use of in-person enrollment assistants stationed within local communities at times and locations convenient to residents.

States noted that concerns about "public charge" were important among immigrant groups.[2] States with large immigrant populations—including California, Florida, and Texas—found that these groups were concerned about how enrollment in SCHIP could affect their chances for citizenship under the public charge clause. These states worked with immigration attorneys or Legal Aid Services to address concerns and develop materials about public charge. Florida distributed an easy-to-read booklet on public charge concerns, but found that it was challenging to overcome deeply held suspicions about government. Similarly, California noted that even with clarification of the public charge issue by the Immigration and Naturalization Service (INS), some immigrant families and advocates were reluctant to apply to Healthy Families based on prior negative experiences and a general distrust of government.

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[2] Under immigration law, an alien who has become or is likely to become dependent on certain kinds of government assistance is known as a "public charge." A public charge is ineligible for admission to the United States and can be deported if government assistance is received within five years of entering the United States. Medicaid and SCHIP coverage are not subject to public charge consideration because they are non-cash benefits that avoid the need for ongoing cash assistance. However, there has been considerable confusion about which benefits are subject to public charge consideration and, as a result, many families have not sought Medicaid or SCHIP coverage for their children.

E. CONCLUSION

Certain common themes about outreach emerged from the information reported in the state evaluations. States consistently rated both mass media and in-person outreach highly, suggesting that no one specific activity was viewed as most effective; rather, it was the combination and complementarity of these types of activities that raised awareness and, ultimately, motivated families to request and submit applications for enrollment. States' numerical ratings of the effectiveness of outreach activities and settings (as reported in the state evaluations) were consistent with information derived from such sources as hotline, application, survey, and event data—namely, that schools, mass media, friends and family, providers, and social service agencies were the most effective referral sources.

Few states performed labor-intensive, one-on-one outreach such as home visits, education sessions, or calls from the state or brokers. Those that did, however, tended to rate these activities as highly effective. This finding is consistent with anecdotal reports from some states that families still benefit from having the program explained to them and receiving assistance with the application.

From the information reported in the evaluations, it appears that some states are moving toward conducting more rigorous evaluation of the effectiveness of their outreach activities. A few states, for example, reported that they are planning to link enrollment, application, and referral source data to measure the effectiveness of various outreach efforts on actual enrollment. These types of outreach studies would help to identify what strategies are most effective in reaching and enrolling children in SCHIP.

VIII. HOW STATES ARE AVOIDING CROWD-OUT OF PRIVATE INSURANCE

Title XXI required states to implement procedures to ensure that health insurance coverage through SCHIP did not displace, or crowd out, private coverage. This provision was included because SCHIP targets children with higher incomes and there were concerns that these children might be more likely to have access to, or to be covered by, employer-sponsored insurance. Crowd-out may occur when employers or families do not choose to take up or voluntarily drop existing private coverage in favor of SCHIP. SCHIP programs may provide two incentives for families to drop existing private coverage: one, SCHIP coverage often has lower costs (that is, premiums and/or copayments) compared to private health insurance coverage; and two, it may provide more comprehensive benefits. Employers, too, may face financial incentives to discontinue dependent coverage or reduce their contributions if SCHIP coverage is available for their low-wage workers.

Title XXI also required that the state plans specify procedures used to ensure that the insurance coverage provided under SCHIP does not substitute for coverage under group health plans. The SCHIP regulations provided additional guidance for states to address this requirement, and articulated specific policies based on the income level of the enrollees and the mechanism for providing coverage.[1]

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[1] The final SCHIP regulations require states, at a minimum, to monitor the extent of substitution occurring in their SCHIP programs, other than SCHIP coverage provided via premium assistance for group health plan coverage. Because of the greater likelihood of substitution when SCHIP eligibility is extended to higher-income families, states that offer coverage to children above 200 percent of poverty are expected to study the extent to which substitution occurs, identify specific strategies to limit substitution if monitoring efforts show unacceptable levels of substitution, and specify a trigger point at which a substitution mechanism would be instituted. States that extend coverage to children above 250 percent of poverty are required to have a crowd-out prevention strategy in place. Substitution protections for premium assistance programs are addressed separately in the final rule.

Title XXI (section 2108(b)(1)(D)) required states in their evaluations to review and assess their activities to coordinate their SCHIP programs with other private programs providing health care. This chapter summarizes states' efforts to prevent, monitor, and measure crowd-out in their SCHIP programs, as reported in the state evaluations. It also addresses the types of crowd-out prevention strategies states are implementing; how states are monitoring the effectiveness of these policies; and states' findings on the extent of crowd-out.

A. OVERVIEW OF PROGRAM FEATURES TO PREVENT CROWD-OUT

States reported using several mechanisms to address crowd-out. A key strategy was to impose waiting periods without insurance coverage, and some states also designed benefits and cost-sharing features to resemble private health insurance coverage. These approaches can reduce incentives for families to decline or drop other coverage, as well as discourage employers from discontinuing dependent coverage. Thirty-seven states required a waiting period without health insurance coverage (Table VIII.1). All states with eligibility thresholds above 200 percent of poverty instituted a waiting period (except Minnesota, which had a very narrow SCHIP program for infants [see Chapter III]). Nineteen of the 25 states with eligibility thresholds at 200 percent of poverty also had a waiting period.

Many states also structured benefits so that they were comparable to those offered in the private health insurance market. As discussed in Chapter IV, 29 states reported that they required cost sharing (such as premiums, copayments, or enrollment fees), and 18 indicated that their cost-sharing design was explicitly intended to address crowd-out (Table VIII.1). Six states also incorporated benefit limits or exclusions to resemble those in private health insurance benefit packages (for example, limits on mental health, durable medical equipment, and therapy services).

TABLE VIII.1

FEATURES OF SCHIP PROGRAMS DESIGNED TO PREVENT CROWD OUT (SORTED BY SCHIP ELIGIBILITY THRESHOLD)

State	Program Type	Maximum Eligibility Threshold	M-SCHIP	S-SCHIP	Waiting Period Without Insurance	Cost-Sharing as an Anti-Crowd Out Feature	Benefit Limits as an Anti-Crowd Out Feature
Total					37	18	6
Arkansas	M-SCHIP	100	100	-			
Tennessee	M-SCHIP	100	100	-			
Wyoming	S-SCHIP	133	-	133	✓		
North Dakota	COMBO	140	100	140	✓*		
Idaho	M-SCHIP	150	150	-			
Louisiana	M-SCHIP	150	150	-	✓		
Montana	S-SCHIP	150	-	150	✓		
South Carolina	M-SCHIP	150	150	-			
Oregon	S-SCHIP	170	-	170	✓		
Colorado	S-SCHIP	185	-	185	✓	✓	✓
Illinois	COMBO	185	133	185	✓*	✓	
Maine	COMBO	185	150	185	✓		
Nebraska	M-SCHIP	185	185	-			
Oklahoma	M-SCHIP	185	185	-			
Wisconsin	M-SCHIP	185	185	-	✓	✓	
New York	COMBO	192	100	192			
Alabama	COMBO	200	100	200	✓*	✓	
Alaska	M-SCHIP	200	200	-	✓		
Arizona	S-SCHIP	200	-	200	✓	✓	
Delaware	M-SCHIP	200	200	-	✓	✓	
District of Columbia	S-SCHIP	200	-	200			
Florida	COMBO	200	100	200			
Georgia	S-SCHIP	200	-	200	✓	✓	
Hawaii	M-SCHIP	200	200	-			
Indiana	COMBO	200	150	200	✓*		
Iowa	COMBO	200	133	200	✓*	✓	
Kansas	S-SCHIP	200	-	200	✓		
Kentucky	COMBO	200	150	200	✓		
Maryland	M-SCHIP	200	200	-	✓		
Massachusetts	COMBO	200	150	200		✓	✓
Michigan	COMBO	200	150	200	✓		
Mississippi	COMBO	200	100	200	✓	✓	
Nevada	S-SCHIP	200	-	200	✓	✓	
North Carolina	S-SCHIP	200	-	200	✓	✓	
Ohio	M-SCHIP	200	200	-			
Pennsylvania	S-SCHIP	200	-	200			
South Dakota	COMBO	200	140	200	✓*		
Texas	COMBO	200	100	200	✓*		
Utah	S-SCHIP	200	-	200	✓	✓	✓
Virginia	S-SCHIP	200	-	200	✓		
West Virginia	S-SCHIP	200	-	200	✓*		
New Mexico	M-SCHIP	235	235	-	✓		
California	COMBO	250	100	250	✓*	✓	
Rhode Island	M-SCHIP	250	250	-	✓		
Washington	S-SCHIP	250	-	250	✓	✓	
Minnesota	M-SCHIP	280	280	-			
Connecticut	COMBO	300	185	300	✓*	✓	✓
Missouri	M-SCHIP	300	300	-	✓	✓	✓
New Hampshire	COMBO	300	300	300	✓*		
Vermont	S-SCHIP	300	-	300	✓		
New Jersey	COMBO	350	133	350	✓*	✓	✓

SOURCE: Mathematica Policy Research analysis of the title XXI State Evaluations, Section 3.6.1 of the State Evaluation Framework.

*Applies to S-SCHIP only.

B. USE OF WAITING PERIODS WITHOUT INSURANCE COVERAGE

Of the 37 states requiring children to be uninsured for one or more months before obtaining coverage under SCHIP, 18 had waiting periods less than 6 months, 17 required a 6-month waiting period, and 2 required that children be uninsured for 12 months (Table VIII.2).[2] In 12 states with combination programs—Alabama, California, Connecticut, Illinois, Indiana, Iowa, New Hampshire, New Jersey, North Dakota, South Dakota, Texas, and West Virginia—waiting periods applied only to the S-SCHIP component.

Many states said that they allowed exceptions to the waiting period when a child became uninsured involuntarily as a result of circumstances beyond the family's control (such as layoffs, job changes, divorce, or the death of a parent) or when employer-sponsored insurance was too expensive (Table VIII.2).[3] The following examples are illustrative of the circumstances under which states waived waiting periods:

- In Missouri, the six-month waiting period was waived when insurance was lost for reasons other than voluntary termination of employment or insurance, including: involuntary loss of employment; employer did not provide dependent coverage; expiration of COBRA coverage;[4] lapse of coverage when maintained by an individual other than the custodial parent or guardian; or lifetime maximum benefits under private insurance had been exhausted.

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[2] The January 11, 2001 final rule clarified that states with an M-SCHIP program could not impose a waiting period unless they sought a waiver to create a waiting period for the Medicaid expansion. Several states are now in the process of coming into compliance with this requirement.

[3] The January 11, 2001 final rule clarified that states could allow exceptions to the waiting period for reasons such as involuntary loss of coverage and affordability.

[4] Title X of the Consolidated Omnibus Budget Reconciliation Act (PL 99-272), commonly referred to as COBRA, was enacted in 1985 and helps workers and their families maintain health coverage when they change or lose their jobs. COBRA requires that group health plans, including self-insured plans, offer qualified part-time and former employees the opportunity to pay for continued coverage under certain conditions. COBRA eligibility is generally limited to 18 months.

TABLE VIII.2

USE OF WAITING PERIODS IN SCHIP PROGRAMS, BY STATE

State	Program Type	Waiting Period	When the Waiting Period Does Not Apply
Alabama	COMBO	3 months[a]	When health insurance has been involuntarily terminated.
Alaska	M-SCHIP	12 months	When income is less than 150 percent of poverty or good cause.
Arizona	S-SCHIP	6 months	When prior coverage was discontinued due to the involuntary loss of employment.
Arkansas	M-SCHIP	None	NA
California	COMBO	3 months[a]	When health coverage was lost due to employment loss or a change in jobs, family moved into an area where ESI is not available, employer discontinued health benefits to all employees, COBRA coverage ended, or child reached the maximum coverage of benefits allowed by current insurance policy.
Colorado	S-SCHIP	3 months	When employer contributed less than 50 percent of the premiums, or prior insurance lost due to loss of or change in employment.
Connecticut	COMBO	6 months[a]	When coverage was dropped due to good cause or medical insurance is minimal.
Delaware	S-SCHIP	6 months	When loss for good cause such as death or disability of parent, termination of employment, a new job that does not cover dependents, change of address to a county where provider network is not available, expiration of coverage under COBRA, or employer terminates coverage for all employees.
District of Columbia	M-SCHIP	None	NA
Florida	COMBO	None	NA
Georgia	S-SCHIP	3 months	When health insurance has been involuntarily terminated.
Hawaii	M-SCHIP	None[b]	NA
Idaho	M-SCHIP	None	NA
Illinois	COMBO	3 months[a]	When insurance has been lost through no fault of the family, or is inaccessible, or does not cover physician and hospital services.
Indiana	COMBO	3 months[a]	When loss of coverage was involuntary or child was previously covered by Medicaid.
Iowa	COMBO	6 months[a]	When the cost of employer-sponsored insurance exceeds 5 percent of gross family income.
Kansas	S-SCHIP	6 months[c]	When prior coverage has been lost due to loss of employment, coverage was dropped by someone other than the custodial parent, or coverage is not accessible because of distance to providers.
Kentucky	COMBO	6 months	When insurance coverage has been terminated for reasons other than voluntary action by the child or the parents.
Louisiana	M-SCHIP	3 months	None reported.
Maine	COMBO	3 months	When the employer contributes less than 50 percent of the premiums, or the family pays over 10 percent of income for family coverage, or the child lost coverage for a reason other than to get coverage.
Maryland	M-SCHIP	6 months	When loss of coverage was due to involuntary termination.
Massachusetts	COMBO	None	NA
Michigan	COMBO	6 months	When insurance coverage was lost involuntarily due to layoff, business closing, or similar circumstance.
Minnesota	M-SCHIP	None	NA
Mississippi	COMBO	6 months[d]	None reported.
Missouri	M-SCHIP	6 months	When loss of employment was due to factors other than voluntary termination; employer does not provide dependent coverage; expiration of COBRA; lapse of coverage when maintained by an individual other than the custodial parent or guardian; or when lifetime maximum benefits under private insurance have been exhausted.
Montana	S-SCHIP	3 months	When parent or guardian dies; was fired or laid off; can no longer work due to a disability; has a lapse in insurance coverage due to new employment; or employer no longer offers dependent coverage.
Nebraska	M-SCHIP	None	NA
Nevada	S-SCHIP	6 months	When insurance coverage terminated due to no fault of applicant.
New Hampshire	COMBO	6 months[a]	When insurance coverage terminated for good cause, including loss of employment; change of employment to an employer who does not provide dependent coverage; death of the employed parent; employee was laid off; or voluntary job loss for good cause.
New Jersey	COMBO	6 months[a]	When paying for an individual health plan or COBRA, or prior coverage was lost due to employer going out of business, employee was laid off, or changed jobs.
New Mexico	M-SCHIP	12 months	When the child moves out of state; is incarcerated in a juvenile corrections facility; or the child loses coverage through involuntary means.
New York	COMBO	None	NA

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TABLE VIII.2 *(continued)*

State	Program Type	Waiting Period	When the Waiting Period Does Not Apply
North Carolina	S-SCHIP	2 months	When the child has special health care needs or is a Medicaid graduate, or insurance was lost through no fault of the family.
North Dakota	COMBO	6 months[a]	When insurance was lost through no fault of the family.
Ohio	M-SCHIP	None	NA
Oklahoma	M-SCHIP	None	NA
Oregon	S-SCHIP	6 months	When the child has a life-threatening condition or disability or was previously enrolled in the Oregon Health Plan.
Pennsylvania	S-SCHIP	None	NA
Rhode Island	M-SCHIP	4 months	When coverage would have cost $50 or more per month per family.
South Carolina	M-SCHIP	None	NA
South Dakota	COMBO	3 months[a]	When lack of insurance is beyond the caretaker's control; the cost of insurance coverage exceeds five percent of the family's gross income; lapse in insurance due to loss of employment, temporary unemployment, lay off, or new employer does not provide coverage immediately upon employment; parent providing the insurance becomes disabled or dies; or employer does not provide dependent coverage or discontinues insurance coverage.
Tennessee	M-SCHIP	None	NA
Texas	COMBO	3 months[a]	None reported.
Utah	S-SCHIP	3 months	When coverage was involuntarily terminated.
Vermont	S-SCHIP	1 month	When insurance is lost due to loss of employment, death or divorce, or other loss of eligibility as a dependent under a parent's policy.
Virginia	S-SCHIP	6 months	When loss of coverage was due to good cause.
Washington	S-SCHIP	4 months	When the child has a life threatening condition or disability or when loss of coverage is due to loss of employment; death of employee; employer discontinues coverage; family's out-of-pocket maximum is $50 or more per month; the plan terminates coverage because the individual reached a lifetime limit; COBRA coverage ends; coverage is not reasonably available; or domestic violence leads to loss of coverage.
West Virginia	S-SCHIP	6 months[a]	When the employer terminates coverage; involuntary layoff; private insurance is not cost-effective; child loses coverage due to parent's job change; or loss of coverage was outside the control of an employee.
Wisconsin	M-SCHIP	3 months[e]	When lack of insurance was due to involuntary loss of employment; new employer does not offer coverage; employer discontinues coverage for all employees; or COBRA coverage ends.
Wyoming	S-SCHIP	1 month	When the parent providing the primary insurance is laid off, fired or can no longer work because of a disability or has a lapse in coverage due to job change.

SOURCE: Mathematica Policy Research analysis of the title XXI State Evaluations, Table 3.1.1 and Section 3.6 of the State Evaluation Framework; annual reports for 2000; and state plan descriptions.

NOTE: The type of SCHIP program is as of March 31, 2001. The state evaluations generally present program characteristics as of September 30, 1999.

[a] Applies to S-SCHIP only.
[b] A 3-month waiting period has been approved, but not implemented.
[c] Effective July 1, 2001, the waiting period in Kansas was dropped.
[d] Effective October 1, 2000, the waiting period in Mississippi was dropped.
[e] A 6-month waiting period applies to the premium assistance component.

NA = not applicable.

ESI = employer-sponsored insurance.

COBRA = Consolidated Omnibus Budget Reconciliation Act.

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- In Maine, the three-month waiting period was waived when the employer covered less than 50 percent of insurance premiums, or the family paid more than 10 percent of income for family coverage, or the child's loss of coverage was for a reason other than simply to get coverage.

Some states reported in their evaluations that waiting periods could be a barrier to families with children with special health care needs. Oregon and Washington, for example, reported that children were exempted from the waiting period requirement if they had life-threatening or disabling conditions. In response to advocate requests, Connecticut reported that it was considering eliminating its six-month waiting period for children with special health care needs.

The mechanism by which families could obtain a waiver varied from state to state. For example, Connecticut required families to file an exception to its six-month waiting period when a child became uninsured involuntarily. Kentucky and Wisconsin made such events automatic exceptions to the waiting period.

Some states noted that they have begun to modify their waiting periods and to expand the exceptions under which the waiting period would be waived. New Jersey and Virginia reduced the waiting period from 12 to 6 months, because of concerns about the hardship imposed on families whose children would be uninsured for a full year before becoming eligible for SCHIP. In addition, New Jersey eliminated its six-month waiting period for families under 200 percent of poverty that either previously purchased individual health insurance policies or reached the end of their COBRA employer-sponsored coverage. North Carolina reduced its waiting period from six to two months, while Mississippi and Kansas eliminated their six-month waiting periods. Hawaii's plan has a provision for a three-month waiting period, but the state never implemented this strategy and later withdrew this strategy from its state plan. New York reported that the state will impose a six-month waiting period if staff find that 8 percent or more of applicants voluntarily drop private coverage for SCHIP coverage.

C. HOW STATES PREVENT CROWD-OUT THROUGH THE ELIGIBILITY DETERMINATION PROCESS

Many states said that they implemented crowd-out prevention activities as part of their eligibility determination process, such as collecting insurance information on the application (41 states), conducting records matches (17 states), and verifying application information with employers (13 states) (Table VIII.3). Seven states—Georgia, Maine, Massachusetts, Missouri, South Carolina, Tennessee, and Texas—engaged in all three activities.

Although most states reported collecting insurance information as part of the application process, they varied widely in what they collected. For example, Ohio and South Dakota asked only whether applicants *currently* had health insurance coverage, while Kentucky asked if applicants had lost coverage in the prior six months, and if so, the reasons why. New York required that all applicants complete a questionnaire providing comprehensive information about coverage history in the past six months, including whether or not they previously were insured through their employers, and, if so, why employer-sponsored coverage was discontinued.[5] Applications were not approved unless the questionnaire was complete. Health plans were responsible for taking applications, determining eligibility, tabulating the questionnaire responses, and reporting the results to the state on a quarterly basis. The state does not have a waiting period but has a policy that if the statewide crowd-out percentage equals or exceeds 8 percent, on average, within a nine-month period, a six-month waiting period may be implemented.

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[5] The questionnaire included the following reasons as to why employer-sponsored coverage was discontinued: employer discontinued offering the benefit, or was no longer contributing towards premium for the enrollee, but continued benefits for the working parent; the premium was increased beyond what was affordable; Child Health Plus was a less expensive insurance alternative; Child Health Plus insurance benefits were better; and the parent was no longer working for the employer who offered the insurance.

TABLE VIII.3

PROCEDURES USED TO SCREEN FOR CURRENT OR PRIOR INSURANCE COVERAGE DURING THE SCHIP ELIGIBILITY DETERMINATION PROCESS

State	Program Type	Collect Information on Current or Previous Insurance	Record Match or Third Party Liability (TPL) Match	Verification of Information with Employer
Total		41	17	13
Alabama	COMBO	✓	✓	
Alaska	M-SCHIP	✓		✓
Arizona	S-SCHIP	✓		
Arkansas	M-SCHIP			
California	COMBO	✓		
Colorado	S-SCHIP	✓		
Connecticut	COMBO	✓		✓
Delaware	M-SCHIP	✓		
District of Columbia	S-SCHIP	✓		
Florida	COMBO	✓		
Georgia	S-SCHIP	✓	✓	✓
Hawaii	M-SCHIP			
Idaho	M-SCHIP	✓		
Illinois	COMBO	✓		✓
Indiana	COMBO	✓	✓	
Iowa	COMBO	✓		
Kansas	S-SCHIP	✓		
Kentucky	COMBO	✓		
Louisiana	M-SCHIP	✓		✓
Maine	COMBO	✓	✓	✓
Maryland	M-SCHIP	✓	✓	
Massachusetts	COMBO	✓	✓	✓
Michigan	COMBO	✓		
Minnesota	M-SCHIP			
Mississippi	COMBO			
Missouri	M-SCHIP	✓	✓	✓
Montana	S-SCHIP	✓	✓	
Nebraska	M-SCHIP	✓	✓	
Nevada	S-SCHIP		✓	
New Hampshire	COMBO	✓		
New Jersey	COMBO	✓		
New Mexico	M-SCHIP			
New York	COMBO	✓		
North Carolina	S-SCHIP			
North Dakota	COMBO			
Ohio	M-SCHIP	✓		
Oklahoma	M-SCHIP			
Oregon	S-SCHIP	✓		
Pennsylvania	S-SCHIP	✓	✓	
Rhode Island	M-SCHIP	✓		✓
South Carolina	M-SCHIP	✓	✓	✓
South Dakota	COMBO	✓		
Tennessee	M-SCHIP	✓	✓	✓
Texas	COMBO	✓	✓	✓
Utah	S-SCHIP			✓
Vermont	S-SCHIP	✓		
Virginia	S-SCHIP	✓		
Washington	S-SCHIP	✓		
West Virginia	S-SCHIP	✓	✓	
Wisconsin	M-SCHIP	✓	✓	
Wyoming	S-SCHIP	✓	✓	

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations, Section 3.6 of the State Evaluation Framework.

NOTE: The type of SCHIP program is as of March 31, 2001. The state evaluations generally present program characteristics as of September 30, 1999.

Seventeen states performed administrative record matches to identify other sources of insurance coverage. Typically, M-SCHIP programs used existing third-party liability procedures designed for traditional Medicaid. Record matches were less common among states with S-SCHIP programs, because they required the integration of data from different sources—such as Medicaid, private insurance, and employment records. Alabama and Wisconsin are two examples of how record matches can be used to integrate eligibility/enrollment information across programs:

- Alabama eligibility workers conducted on-line verification with the Blue Cross/Blue Shield (BC/BS) database at the time the application was reviewed. The BC/BS enrollment file contains not only current enrollment, but also indicates whether enrollment was canceled in the past 12 months. If enrollment was voluntarily terminated within 90 days of the application, the child cannot be enrolled in SCHIP until 90 days have elapsed. Because BC/BS insures approximately 85 percent of the population, on-line verification against BC/BS insurance coverage data has made the eligibility process more efficient and assures coordination with private insurance. The state plans to add enrollment data from other private insurance companies in the future.
- Wisconsin eligibility workers screened BadgerCare applicants for Medicaid eligibility and then performed monthly and semi-annual data matches of all current Medicaid and BadgerCare enrollees, using health care coverage information submitted by local and national insurance carriers that sell or issue health care policies to residents of Wisconsin. Any resulting match automatically updated insurance coverage information in the eligibility record.

Thirteen states noted that they verified applicants' insurance coverage information with employers. Employer verification typically requires staff to contact the employer, by phone or mail, to verify income, insurance coverage status, and other information, and then to review all the application information before a final eligibility determination can be made. States varied in how they implemented employer verification processes and the type of data they collected:

- In Connecticut, the enrollment broker spot-checked 20 percent of the approved applications with employers to verify access to employer-sponsored insurance.
- For uninsured children with access to ESI, Massachusetts evaluated whether the insurance coverage available through the employer met the state's benchmark benefit

level and was cost effective to the state. If so, the family was instructed to enroll in the empoyer's plan. If not, the children were enrolled in the direct coverage program under SCHIP.

- Wisconsin conducted a "post-eligibility" employer verification check. Applicants were given presumptive eligibility for SCHIP while this process took place. The state sent a form to an applicant's or applicant family member's employer to gather information about the type of health plan offered, the cost of the plan, and the employer share of the premium.

Seven states reported using other eligibility determination procedures to deter crowd-out. Some examples are:

- Arizona used random enrollee audits to check other insurance coverage at the time of enrollment.
- North Carolina required insurance companies, social workers, and providers to report SCHIP enrollees who have other coverage to the state.
- Illinois automatically enrolled SCHIP applicants who had other insurance in its state-funded KidCare Rebate program, which provides premium assistance for private insurance coverage.

D. STATE APPROACHES TO MONITORING AND MEASURING CROWD-OUT

States varied in their approaches to monitoring and measuring crowd-out. As discussed in the previous section, most states gathered information about current and previous insurance coverage to determine eligibility. Not all states, however, used this information for monitoring crowd-out. Based on information reported in the state evaluations, 30 states had an active monitoring process to assess the extent of crowd-out (Table VIII.4). States used the following methods to monitor crowd-out:

- Of the 41 states collecting information on current and/or previous insurance status on the application (recall Table VIII.3), 19 reported that they used this information for monitoring purposes (Table VIII.4). Seven states indicated that they used this information to construct application-denial rates, for example, the percent of applicants who currently had other coverage or who failed to fulfill the waiting period. Some states that collected information only on applicants' current coverage

TABLE VIII.4

APPROACHES USED TO MONITOR CROWD OUT IN SCHIP PROGRAMS

State	Program Type	Active Monitoring Process	Collect Information From Application on Current/Previous Insurance	Perform Record Match/Third-Party Liability (TPL) Match	Health Plan or Other Third-Party Monitors	Survey
Total		30	19	6	6	9
Alabama	COMBO	✓		✓		✓
Alaska	M-SCHIP					
Arizona	S-SCHIP	✓	✓		✓	
Arkansas	M-SCHIP					
California	COMBO	✓	✓			
Colorado	S-SCHIP	✓	✓			
Connecticut	COMBO	✓	✓		✓	
Delaware	M-SCHIP					
District of Columbia	S-SCHIP	✓	✓			
Florida	COMBO	✓	✓			✓
Georgia	S-SCHIP					
Hawaii	M-SCHIP					
Idaho	M-SCHIP					
Illinois	COMBO					
Indiana	COMBO	✓	✓			
Iowa	COMBO					
Kansas	S-SCHIP	✓	✓			
Kentucky	COMBO	✓	✓		✓	
Louisiana	M-SCHIP	✓				
Maine	COMBO	✓				✓
Maryland	M-SCHIP					
Massachusetts	COMBO					
Michigan	COMBO	✓	✓			
Minnesota	M-SCHIP					
Mississippi	COMBO					
Missouri	M-SCHIP	✓		✓		✓
Montana	S-SCHIP	✓				✓
Nebraska	M-SCHIP	✓			✓	
Nevada	S-SCHIP					
New Hampshire	COMBO	✓	✓			
New Jersey	COMBO	✓	✓			
New Mexico	M-SCHIP					
New York	COMBO	✓	✓		✓	
North Carolina	S-SCHIP	✓				✓
North Dakota	COMBO					
Ohio	M-SCHIP	✓	✓			✓
Oklahoma	M-SCHIP					
Oregon	S-SCHIP	✓	✓			
Pennsylvania	S-SCHIP	✓	✓	✓		
Rhode Island	M-SCHIP	✓			✓	
South Carolina	M-SCHIP					
South Dakota	COMBO	✓				✓
Tennessee	M-SCHIP					
Texas	COMBO	✓		✓		
Utah	S-SCHIP	✓				✓
Vermont	S-SCHIP					
Virginia	S-SCHIP	✓	✓			
Washington	S-SCHIP					
West Virginia	S-SCHIP	✓	✓	✓		
Wisconsin	M-SCHIP	✓	✓	✓		
Wyoming	S-SCHIP					

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations, Section 3.6.2 of the State Evaluation Framework.

NOTE: The type of SCHIP program is as of March 31, 2001. The state evaluations generally present program characteristics as of September 30, 1999.

status, such as South Dakota and Ohio, relied on other means to monitor crowd-out (enrollee surveys and CPS data, respectively).

- Of the 16 states that conducted record matches as part of the eligibility determination process, 6 reported that they used record matching or TPL information to monitor crowd-out. Missouri, for example, maintained various databases to identify members with other insurance coverage and relied on its Medicaid TPL unit to check for potential crowd-out. Massachusetts plans to use this method to measure crowd-out in the future.
- Nine states used enrollee surveys to monitor crowd-out, and three other states—Wisconsin, Illinois, and Massachusetts—plan to implement enrollee surveys in the future.
- Six states reported using other methods to monitor crowd-out. Arizona audited applications retrospectively and interviewed enrollees about their prior insurance status. Five states delegated crowd-out monitoring: Connecticut, New York, and Rhode Island used health plans, while Nebraska and Kentucky delegated this responsibility to other third parties, such as the enrollment broker or a state-level committee.

E. EARLY FINDINGS ON THE EXTENT OF CROWD-OUT UNDER SCHIP

The information presented in the state evaluations suggests that states do not perceive crowd-out to be a major problem under SCHIP.[6] Of the 16 states that presented evidence in their state evaluations, 8 reported that they detected no crowd-out, 5 reported rates of less than 10 percent, and 3 reported rates between 10 and 20 percent.

The eight states that reported that little or no crowd-out was detected based their determinations on survey findings, reports from other third parties such as health plans, a records match, or other type of information.

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[6] It is important to consider several caveats when reviewing the information presented by states on crowd out. First, there is no commonly agreed upon definition with which to measure crowd out and state approaches vary. For example, states used different reference periods to recall health insurance coverage and some states made a distinction based on access versus affordability. Second, some states did not report the methodology or sample sizes used in their analysis of crowd out. Third, there is no uniform reporting method. For example, some states measured crowd out in the aggregate while others reported percentages.

- Alabama stated that crowd-out is not a significant problem with the ALL Kids program, given its record matching process against BC/BS membership files. The BC/BS file contains not only current enrollment, but also enrollment in the last 12 months. In addition, a survey of first-year enrollees revealed that three-fourths were uninsured for longer than six months (Alabama had a three-month waiting period).

- Connecticut tracked the number of families filing for exceptions to the state's six-month waiting period and reported that "this is not happening often."

- New Hampshire identified only one family who appeared to have deliberately dropped private insurance in order to qualify for SCHIP. This analysis was based on information gathered on the SCHIP application form.

- New Jersey denied 531 applications where the child had insurance at the time of application, and another 71 applications because the applicant had coverage within the 6-month waiting period. These statistics were for the period May 1, 1998 through September 30, 1999.

- Oregon denied coverage to about 34 applicants per month because they had coverage within the past six months. About 90 percent of those denied coverage were insured at the time of application.

- Pennsylvania used several approaches to measure the effectiveness of its crowd-out prevention procedures. The state performed a record match against commercial enrollment files and concluded "less than .01 percent [of applicants] were found to have been enrolled in a commercial product of a SCHIP contractor when a match was completed." The state also examined reasons for denial and found that, of the applications rejected for any reason, 5 percent were rejected because the child had private insurance, and another 15 percent were potentially eligible for Medicaid. The state also reviewed terminated cases at the time of recertification and found that about 9 percent lost SCHIP eligibility because private insurance was available to the child and another 15 percent lost SCHIP eligibility because they were eligible for Medicaid.

- Rhode Island relied on reports from health plans regarding shifts in coverage, and stated that no measurable crowd-out had been reported by its health plans.[7]

- Utah's survey of enrollees showed that enrollees were uninsured for an average of 13 months before applying to SCHIP, "suggesting that crowd-out is not a problem." The state also noted that, because SCHIP benefits were similar to those offered by private insurance plans, families did not face an incentive to drop their private coverage.

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[7] Rhode Island's FFY 2000 Annual Report provided updated evidence that crowd-out was a significant concern to the state, particularly affecting parents enrolled under Section 1931 provisions. One health plan reported that about 30 percent of its new RIte Care enrollees had dropped commercial insurance coverage and directly enrolled in RIte Care. Among the factors accounting for the shift were: expansions in RIte Care eligibility, success of outreach efforts, increases in commercial premiums over the past year, and lack of effective anti-crowd-out provisions. As a result, Rhode Island sought and obtained approval for a Medicaid 1115 demonstration, which will enable the state to implement affordability tests and waiting periods for new applicants and to redesign the cost-sharing provisions.

Five states reported that fewer than 10 percent of enrollees had coverage at the time of enrollment or within the waiting period. These states measured crowd-out based on information collected from applications or enrollee surveys.

- California analyzed application data and found that 3.8 percent of its enrollees had job-based coverage within the prior 90 days. However, about three-fifths of these children would have been uninsured due to loss of employment.
- Missouri conducted an enrollee survey as part of a broader Medicaid evaluation and estimated a crowd-out rate between 1.6 percent and 3.2 percent of its enrollees. (Crowd-out was not defined in this context.) The state also performed routine checks through its Third Party Liability Unit, to identify members that should be disenrolled due to other insurance coverage..
- New York State law required each applicant to complete a questionnaire on prior insurance status as part of the application process. The state reported a crowd-out rate of 4.9 percent, which reflected three components: enrollees whose employers discontinued coverage, enrollees who found SCHIP to be less expensive, and enrollees who found SCHIP benefits to be better. Of those enrollees who had coverage within the prior six months, nearly 60 percent indicated that coverage was discontinued because of loss of employment or because benefits were unaffordable.
- North Carolina reported the results of an enrollee survey that estimated crowd-out between 0.7 and 8.3 percent. The former figure reflected those applicants who stated they had intentionally dropped coverage prior to applying to SCHIP; the latter figure included respondents who had access to, but could not afford employer-sponsored insurance, as well as those who chose SCHIP because their existing coverage did not pay for as many services as SCHIP.
- South Dakota used a mail and telephone survey of enrollees to gauge crowd-out. In December 1999, a random sample of 544 households (20 percent of households with M-SCHIP enrollees) was contacted, and 309 (57 percent) responded. The state reported that only three enrollees (1 percent) had dropped insurance coverage because of the availability of M-SCHIP. Most of the enrollees indicated they did not have health insurance, either because their employer did not offer it or because the cost was too high.

Three states reported that 10 to 20 percent of applicants or enrollees had insurance either at the time of application or within the 12-month period prior to enrollment.

- The District of Columbia reported that 15 percent of all applicants checked the box stating they had dropped health insurance within three months of applying for DC Healthy Families (the District does not have a waiting period). The District was unable to report on the percentage of those who checked the box who ultimately enrolled in SCHIP, although officials "suspect that not all individuals who state they dropped insurance actually enrolled." The District is evaluating ways to track how many who dropped insurance ultimately enrolled.
- Florida's enrollee survey showed that 11 percent of KidCare enrollees had private coverage at any time in the 12 months preceding eligibility (Florida does not have a waiting period for coverage). At the time of the phone survey, 24 percent of HealthyKids enrollees and 21 percent of MediKids had access to employer-based coverage, although many families reported that they could not afford the premium.
- Maine conducted an enrollee survey in 1999 and found that 18 percent of its enrollees had private insurance coverage in the 12 months before enrolling in SCHIP (Maine had a three-month waiting period). About one-third of these enrollees dropped coverage because it was too expensive, another third lost coverage because of job loss or change, and most of the remainder lost insurance due to changes in family circumstances, such as divorce, separation, or relocation. Five percent dropped coverage when they became eligible for SCHIP. At the time of the survey, 24 percent of children were eligible for employer-sponsored coverage, but 89 percent reported that cost prohibited them from taking up coverage, while 11 percent indicated the plans did not cover needed services.

F. CONCLUSION

Most states reported that they were not experiencing crowd-out as a result of SCHIP. Only a few states reported levels of potential substitution in excess of 10 percent. States attributed the lack of crowd-out to their use of preventive strategies such as waiting periods without insurance coverage and their efforts to design their programs to resemble private health insurance coverage. As a result, some states reported that they are beginning to relax their waiting period requirements.

Most states allowed exceptions to their waiting periods to ensure that children who needed coverage did not go without coverage. For example, some states allowed exceptions when a child became involuntarily uninsured as a result of circumstances beyond a family's control. Other states waived waiting periods based on the affordability of employer-sponsored coverage or based on whether the child had a special health care need. The mechanisms by which individuals could request an exception also varied across states. Some states required individuals to file an exception, while others granted an exception automatically as part of the application process.

Although states were almost unanimous in their belief that little or no crowd-out was occurring under SCHIP, the data must be examined carefully, considering the variation from state to state in defining, collecting data on, and monitoring crowd-out. Furthermore, states had limited experience upon which to base the assessments presented in their state evaluations. Whether substitution in SCHIP becomes a factor may need to be reevaluated as states gain more experience with implementation or elect to use SCHIP to cover children at higher income levels.

IX. STATE PROGRESS TOWARD REDUCING THE NUMBER OF UNINSURED LOW-INCOME CHILDREN

The objective of SCHIP, as specified in the title XXI legislation, is to "provide funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children." In their state evaluations, states were required to discuss their progress toward meeting this goal, as mandated in section 2108(b)(1)(A) of the legislation. This is one of the most elusive outcomes to measure, however, due to the lack of precise, consistent, and timely data. Moreover, by March 31, 2000, when states were required to submit their evaluations, many states had been operational for only 18 to 24 months, further challenging states' efforts to document their progress.

To facilitate the tracking of state progress, CMS required each state to derive and report a baseline estimate of the number of uninsured, low-income children in the target population prior to the advent of SCHIP. As part of the state evaluations, states were required to measure their progress against their baselines or to use another methodology to document their success in reducing the number of uninsured, low-income children.

Section A presents state baseline estimates of the number of uninsured children prior to SCHIP, and Section B synthesizes state reports on their progress toward reducing the number of uninsured children. In addition to presenting evidence of their progress in covering children under SCHIP, states documented their efforts in enrolling eligible children under Medicaid.

Although there are significant data limitations inherent in the states' estimates (many of which the states acknowledge), the cumulative evidence suggests that states have made significant strides in reducing the number of uninsured, low-income children.

A. STATE BASELINE ESTIMATES OF UNINSURED CHILDREN

CMS provided guidance to states on the options for producing baseline estimates, recognizing that it would not be possible to rely on a single data source and methodology for all states (HCFA 1998). CMS identified the following sources: published estimates from the Current Population Survey (CPS), a statistically-adjusted estimate from the CPS, or state-specific surveys. Although the CPS is widely acknowledged as the most consistent source of longitudinal data on the number and rate of uninsured children, it is also widely acknowledged to have significant data limitations, especially for producing state-level estimates. State concerns about the CPS design—as reflected in their state evaluations—included:

- Small sample sizes at the state level, especially when disaggregated by age and poverty level
- Year-to-year volatility in the CPS uninsured estimates
- Prior-year reference period for insurance status may be biased toward current coverage (that is, point-in-time)
- Lack of up-to-date population counts
- Undercounting of children enrolled in Medicaid

The Medicaid undercount is particularly problematic, since it may lead to overestimates of the uninsured in the target population. As Michigan noted, "It is believed that . . . a significant number of Medicaid beneficiaries report they do not have health insurance either because they do not consider Medicaid to be health insurance or because they do not want to be associated with what they perceive to be a welfare stigmatized program." Maryland highlighted the significance of the Medicaid undercount relative to state administrative data. Actual Medicaid enrollment in Maryland's Medicaid program totaled 243,000 in 1997, compared to the March 1998 CPS count of 151,000. The disparity was even greater in 1998; the actual count was 248,000, while the March 1999 CPS count was 43,000. The state indicated that part of the disparity may be related to the fact that the CPS did not use the correct state-specific term for Maryland's Medicaid program in 1998 (HealthChoice).

States indicated other concerns related to the application of CPS for producing baseline estimates or simulating the number of potential eligibles:

- CPS measures of income reflect annual income, whereas eligibility determination often is based on one month of income at a given point-in-time; therefore, families with income that varies by month may be eligible depending on the point in time that the application is made. Moreover, in states with 12-month continuous coverage, children would remain eligible regardless of changes in income or insurance status. (Nebraska)
- CPS does not directly count those with part-year coverage; instead, CPS counts the number ever enrolled in each type of coverage during the year. A more relevant measure for simulation efforts would be the number uninsured at any time during the year. (Alaska, New York)
- CPS estimates of the uninsured include children of state employees and individuals leaving welfare, even though there are limits on their eligibility for public insurance. (Georgia)

Despite the data limitations noted above, the CPS was the most commonly used source of data for the baseline estimates, as shown in the following table:

Data Source for Baseline Estimate	All States	M-SCHIP	S-SCHIP	Combination
Total	51	17	16	18
CPS	30	13	8	9
Unadjusted	6	1	3	2
With statistical adjustments	24	12	5	7
State-specific surveys	15	4	4	7
Unknown data source	5	0	3	2
No baseline estimate	1	0	1	0

Thirty states used the CPS to derive estimates of the number of uninsured, low-income children prior to SCHIP implementation. When asked to assess the reliability of their baseline estimates, most states acknowledged the limitations of CPS but indicated that it was the best data source available. Six states used the three-year averages developed by the Census Bureau.[1] Maryland, for example, indicated it decided to use the Census Bureau estimate because this was the basis for distributing the FFY 1998 SCHIP allotments.

Twenty-four states made statistical adjustments to CPS data to compensate for its limitations, such as using synthetic estimation techniques to produce state- or substate-level estimates, adjusting for the Medicaid undercount, applying CPS percentages to more current population projections, or netting out counts of certain ineligible populations (such as immigrants or children of state employees). For example:

- Colorado derived county-level uninsured rates from CPS, using the methodology developed by Diehr et al. (1991); then applied the percentages to 2000 population projections; and finally applied the American Academy of Pediatrics' estimate that SCHIP eligibles under 200 percent of poverty comprise 40.1 percent of the total uninsured in a state.
- Idaho relied on 1997 CPS data on the uninsured rate, and applied the estimates to 2000 population projections to reflect population growth. Similarly, Missouri used 1996 CPS data and updated the projections to 1996 population estimates.
- North Carolina used the 1995-1997 estimates of insurance coverage, applied them to 1997 population data, and netted out the number of children covered by Medicaid (based on state Medicaid eligibility data for September 1997), as well as the number with non-Medicaid insurance according to the 1995-1997 CPS.

Another 15 states opted to produce their baseline estimates based on state-specific surveys: Florida, Hawaii, Illinois, Kentucky, Maine, Michigan, New Hampshire, North Dakota, Ohio, Oregon, Tennessee, Utah, Vermont, Washington, and Wisconsin. Most of these states invested state resources to field a household survey that would improve on the reliability of the CPS. In addition to offering larger sample sizes, these surveys often addressed state concerns about the instrumentation of the CPS health insurance questions.

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[1] In some cases, the state evaluations were ambiguous about which years of CPS data the states used for their baseline estimates. It is unclear whether they referred to the reference year of the survey or the year of the supplement (for example, 1999 could refer to the March 2000 survey with a 1999 reference year, or the March 1999 survey with a 1998 reference year).

Finally, five states (Connecticut, Delaware, Mississippi, Virginia, and West Virginia) did not provide enough detail to determine the primary source or methodology, while one state (Nevada) did not report a baseline estimate in its state evaluation.

Table IX.1 provides a detailed summary of state approaches to constructing their baseline estimates, together with three-year averages of the number of uninsured, low-income children, constructed by the U.S. Bureau of the Census using CPS data.

B. STATE ESTIMATES OF THEIR PROGRESS TOWARD REDUCING THE NUMBER OF UNINSURED CHILDREN

Measurement of state progress toward reducing the number of uninsured children is challenging because of the limitations of state-level baseline data on the number of children uninsured prior to SCHIP (as discussed earlier), as well as lags in obtaining data on the number of uninsured children since SCHIP was implemented. Other barriers include the lack of consistent measures over time and inadequate sample sizes to develop reliable measures.

This section presents state assessments of their progress toward reducing the number of uninsured children as a result of SCHIP. A significant caveat, one noted by states, was the lack of current data that could be used to document progress at the time they completed their state evaluations (that is, March 31, 2000). Data from selected states are presented to demonstrate early evidence of progress. These examples offer a snapshot of state progress as of the time they completed their state evaluations.[2]

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[2] Two states, Hawaii and Nevada, did not complete this section of the evaluation.

TABLE IX.1

STATE BASELINE ESTIMATES OF UNINSURED CHILDREN, AS REPORTED IN FFY 1998 ANNUAL REPORTS AND STATE EVALUATIONS

			Current Population Survey (CPS) Estimates of the Uninsured Population Under Age 19 At or Below 200% of the Federal Poverty Level (FPL)				
State	Baseline Estimate	Methodology	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999
Alabama	168,600 total uninsured children, of which 64,000 were below 100% FPL and 48,900 were between 101% and 200% FPL.	Based on March 1994 CPS estimate developed by the Southern Institute on Children and Families.	154,000 (26,300)	145,000 (25,100)	125,000 (23,000)	115,000 (22,400)	106,000 (21,300)
Alaska	11,600 uninsured children under age 19 below 200% of the Alaska FPL.	Based on March 1995-1997 CPS analysis by Employee Benefits Research Institute (ERBI).	9,000 (2,100)	12,000 (2,700)	18,000 (3,400)	18,000 (3,400)	18,000 (3,400)
Arizona	311,000 uninsured children under age 19 at or below 200% FPL.	Based on March 1997-1999 CPS, three-year average, developed by the U.S. Census Bureau.	184,000 (27,500)	239,000 (31,100)	282,000 (34,300)	309,000 (35,600)	272,000 (33,600)
Arkansas	99,752 uninsured children.	Based on 1989 and 1993 CPS estimates, developed by the Southern Institute on Children and Families.	90,000 (15,100)	98,000 (15,700)	130,000 (18,000)	131,000 (18,300)	111,000 (16,500)
California	328,000 uninsured children eligible for the Healthy Families Program (HFP) and 788,000 eligible for Medi-Cal.	Based on March 1998 CPS. Includes children ages 1-18 with family income between 100% and 199% FPL who were uninsured and ineligible for Medi-Cal. Statistical adjustments were made to (1) reflect the number of undocumented uninsured children who are ineligible for HFP and (2) account for differences in measurement of income under CPS versus HFP. The adjustments reduce the number of children eligible for HFP and raise the number eligible for Medi-Cal. The UCLA Center for Health Policy developed the estimates.	1,281,000 (78,200)	1,259,000 (80,900)	1,216,000 (81,100)	1,258,000 (82,500)	1,244,000 (82,200)

Table IX.1 *(continued)*

			Current Population Survey (CPS) Estimates of the Uninsured Population Under Age 19 At or Below 200% of the Federal Poverty Level (FPL)				
State	Baseline Estimate	Methodology	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999
Colorado	172,457 total uninsured children, of which 69,157 are eligible for SCHIP.	Based on three-year average of March 1995-1997 CPS data to estimate the rate of uninsured children by county, using the methodology developed by Diehr et al. (1991), applied to population projections for 2000, and adjusted by the American Academy of Pediatrics' estimate that SCHIP eligibles under 200% FPL comprise 40.1% of the total uninsured in a state.	72,000 (17,200)	92,000 (19,100)	94,000 (19,400)	87,000 (18,500)	88,000 (18,400)
Connecticut	57,000 uninsured children under age 19 below 200% FPL.	Based on March 1997-1999 CPS, three-year average, developed by the U.S. Census Bureau.	53,000 (15,400)	55,000 (15,600)	58,000 (15,800)	57,000 (15,500)	53,000 (15,000)
Delaware	13,000 uninsured children under age 19 below 200% FPL.	Estimate derived by the University of Delaware's Center for Applied Demographic and Survey Research, based on assumption that 10% of the population is uninsured, and adjusted for recent population growth.	13,000 (3,300)	15,000 (3,700)	19,000 (4,200)	23,000 (4,600)	19,000 (4,300)
District of Columbia	14,749 uninsured children below 200% FPL.	Based on the 1995-1996 CPS, with adjustments to: (1) the population counts based on Census Bureau population projections; (2) the CPS Medicaid enrollment counts based on actual Medicaid enrollment data; and (3) the number of undocumented immigrants (who would be ineligible for Medicaid and SCHIP). Simulation of SCHIP eligibility and enrollment was derived using the Lewin Group State Medicaid Eligibility Model (SMEM).	16,000 (3,300)	12,000 (3,000)	11,000 (2,800)	13,000 (2,900)	12,000 (2,900)
Florida	140,084 uninsured children potentially eligible for SCHIP and 232,305 potentially eligible for Medicaid but not enrolled.	Based on the 1999 Florida Health Insurance Study, conducted by the University of Florida.	444,000 (38,900)	421,000 (40,800)	440,000 (42,500)	426,000 (42,000)	420,000 (41,400)

Table IX.1 *(continued)*

State	Baseline Estimate	Methodology	Current Population Survey (CPS) Estimates of the Uninsured Population Under Age 19 At or Below 200% of the Federal Poverty Level (FPL)				
			1993-1995	1994-1996	1995-1997	1996-1998	1997-1999
Georgia	267,125 uninsured children under age 19 at or below 200% FPL, of which 119,558 are potentially eligible for SCHIP and 147,567 are potentially eligible for Medicaid.	Based on analysis of 1997-1999 CPS by the Center for Risk Management and Insurance Research, Georgia State University.	214,000 (38,300)	215,000 (36,800)	249,000 (38,100)	253,000 (39,200)	237,000 (37,500)
Hawaii	4,458 uninsured low income children.	Based on 1998 State Department of Health's Hawaii Health Survey.	13,000 (4,200)	14,000 (4,500)	13,000 (4,400)	14,000 (4,400)	17,000 (5,000)
Idaho	41,331 uninsured children ages 0-18, with incomes at or below 200% FPL in 1998, of which 34,805 are at or below 150% FPL (the state's eligibility threshold).	Based on 1997 CPS data, adjusted to 2000 population projections to reflect recent population growth.	31,000 (5,600)	31,000 (5,800)	38,000 (6,500)	45,000 (7,300)	53,000 (7,800)
Illinois	190,783 uninsured children below 185% FPL, of which 146,948 are at or below 133% FPL and 43,835 are between 134% and 185% FPL.	Based on mixed-mode Illinois survey of households with children under age 19 in families with adjusted gross income below 250% FPL. The survey included both telephone and in-person components to reduce bias.	211,000 (27,600)	196,000 (28,100)	221,000 (30,300)	277,000 (34,400)	295,000 (35,600)
Indiana	129,000 uninsured children below 200% FPL, of which 36,000 would be eligible for the SCHIP Medicaid expansion as of July 1, 1998; 55,000 uninsured children eligible for Medicaid but not enrolled.	Based on 1996 CPS uninsured rates derived by EBRI, applied to 1999 population projections by poverty level (which were imputed based on 1996-1997 CPS estimates of child poverty rates).	131,000 (29,300)	121,000 (27,500)	121,000 (26,000)	123,000 (26,900)	122,000 (27,000)

Table IX.1 *(continued)*

			Current Population Survey (CPS) Estimates of the Uninsured Population Under Age 19 At or Below 200% of the Federal Poverty Level (FPL)				
State	Baseline Estimate	Methodology	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999
Iowa	67,000 uninsured children below 200% FPL; 15,500 are estimated to be eligible under the SCHIP Medicaid expansion and 39,500 are estimated to qualify for HAWK-I, Phase II (separate SCHIP program).	Based on three-year average of CPS data for 1993-1995.	67,000 (14,100)	71,000 (14,600)	60,000 (13,400)	51,000 (12,400)	42,000 (11,400)
Kansas	60,000 uninsured children below 200% FPL.	Based on three-year average of CPS data for 1993-1995.	60,000 (12,100)	52,000 (12,000)	53,000 (12,000)	42,000 (10,800)	52,000 (11,600)
Kentucky	139,000 total uninsured children, of which 111,000 are below 200% FPL. Of those children, 63,000 are below 100% FPL, 33,000 are between 101% and 150% FPL, and 15,000 are between 151% and 200% FPL.	Based on 1998 Kentucky Health Insurance Survey. The Kentucky Legislative Research Commission developed the estimates.	93,000 (19,500)	116,000 (21,500)	113,000 (21,100)	109,000 (20,400)	98,000 (19,700)
Louisiana	224,600 uninsured low-income children, of which 82,300 are eligible for LaCHIP and 142,300 are eligible for Medicaid but not enrolled.	Based on 1996 CPS with "some extrapolations" and "numerous assumptions" (not specified) due to small sample sizes.	194,000 (30,600)	180,000 (27,800)	189,000 (27,800)	175,000 (26,600)	183,000 (26,800)
Maine	7,835 uninsured children between 125% and 200% FPL potentially eligible for SCHIP.	Based on a random household survey sponsored by the State of Maine and conducted in 1999. Results are preliminary, pending completion of the survey.	24,000 (10,200)	27,000 (6,500)	29,000 (6,700)	25,000 (6,300)	19,000 (5,500)
Maryland	100,000 uninsured children under age 19 at or below 200% FPL.	Based on 1993-1995 CPS data, used by HCFA for distributing the FFY 1998 SCHIP allotment.	100,000 (24,300)	101,000 (24,600)	90,000 (22,900)	93,000 (23,200)	90,000 (23,200)

Table IX.1 *(continued)*

State	Baseline Estimate	Methodology	Current Population Survey (CPS) Estimates of the Uninsured Population Under Age 19 At or Below 200% of the Federal Poverty Level (FPL)				
			1993-1995	1994-1996	1995-1997	1996-1998	1997-1999
Massachusetts	77,214 uninsured children under age 19 at or below 200% FPL.	Based on combined 1995-1997 CPS data, which estimates the level and type of insurance of children in three age groups: birth -7, 8-12, and 13-17 years of age.	69,000 (11,300)	75,000 (15,200)	78,000 (16,500)	70,000 (15,500)	68,000 (15,100)
Michigan	106,000 uninsured children in families with income at or below 200% FPL.	Based on Michigan-specific data from the 1997 National Survey of American Families by the Urban Institute.	156,000 (20,900)	142,000 (22,700)	142,000 (23,500)	158,000 (24,900)	163,000 (25,600)
Minnesota	30 uninsured children, between ages 0 and 2 who were in families with incomes between 275% and 280% FPL, of which 15 would enroll.	Based on CPS data by age and income; assumed that 2% of the target population was uninsured and that 1% would enroll.	50,000 (16,000)	60,000 (16,700)	53,000 (15,900)	67,000 (17,500)	64,000 (17,500)
Mississippi	15,000 children ages 15 to 18 below 100% FPL who are eligible for the first phase of the SCHIP program; another 41,751 uninsured children are eligible for Medicaid but not enrolled.	Based on Heritage Foundation and Urban Institute estimates combined with state estimates.	110,000 (16,500)	114,000 (17,600)	123,000 (18,300)	127,000 (18,600)	114,000 (17,800)
Missouri	194,434 uninsured children, of which 91,301 would be eligible for SCHIP and 78,267 would be eligible for traditional Medicaid.	Based on 1996 CPS, adjusted to updated 1996 population projections by age.	97,000 (24,100)	104,000 (24,800)	113,000 (25,700)	104,000 (24,700)	75,000 (20,900)
Montana	19,000 uninsured children under age 19 below 200% FPL.	Based on 1994-1996 CPS.	20,000 (4,100)	19,000 (4,100)	34,000 (5,400)	32,000 (5,200)	33,000 (5,300)
Nebraska	24,000 uninsured children at or below 185% FPL.	Based on March 1993-1995 CPS and analysis of March 1995 CPS by the Employee Benefit Research Institute.	30,000 (7,000)	28,000 (6,800)	23,000 (6,400)	19,000 (5,800)	22,000 (6,200)

Table IX.1 *(continued)*

State	Baseline Estimate	Methodology	Current Population Survey (CPS) Estimates of the Uninsured Population Under Age 19 At or Below 200% of the Federal Poverty Level (FPL)				
			1993-1995	1994-1996	1995-1997	1996-1998	1997-1999
Nevada	Did not report.	Did not report.	43,000 (7,700)	45,000 (8,900)	56,000 (10,200)	62,000 (10,900)	77,000 (12,000)
New Hampshire	26,000 uninsured low-income children, of which 15,860 are eligible for Medicaid or SCHIP.	Based on 1999 New Hampshire household insurance survey, a telephone survey of 12,000 households carried out by the Office of Planning and Research.	20,000 (5,600)	18,000 (5,100)	15,000 (5,000)	17,000 (5,200)	11,000 (4,200)
New Jersey	274,000 uninsured children potentially eligible for Medicaid or SCHIP, of which 119,000 would be eligible for traditional Medicaid, 41,000 for the SCHIP Medicaid expansion, and 114,000 for the separate SCHIP program (up to 350% FPL with a 6-month waiting period).	Adjusted estimates based on March 1997 CPS and enhanced with other data developed by Mathematica Policy Research; projections to January 1, 2000.	134,000 (17,700)	159,000 (22,500)	176,000 (24,900)	166,000 (24,100)	131,000 (21,200)
New Mexico	94,500 uninsured children below 185% FPL.	Based on 1996 CPS estimate of total uninsured children, adjusted for population growth from 1996 to 1997, and proportionally allocated by poverty level according to the percentage of uninsured children below 185% FPL in the 1993 Robert Wood Johnson Foundation Family Survey of Health Insurance in New Mexico.	107,000 (13,000)	109,000 (13,600)	111,000 (13,700)	86,000 (12,100)	93,000 (12,300)
New York	540,000 uninsured children living in households with incomes below 192% FPL.	Based on March 1997 and 1998 CPS data for New York State, using the Census Bureau's definition of the uninsured and its procedure for expressing family income as a percentage of the poverty level. A two-year average was used to offset irregular patterns in the data.	399,000 (35,100)	441,000 (39,700)	474,000 (42,300)	490,000 (43,100)	448,000 (41,200)

Table IX.1 *(continued)*

State	Baseline Estimate	Methodology	Current Population Survey (CPS) Estimates of the Uninsured Population Under Age 19 At or Below 200% of the Federal Poverty Level (FPL)				
			1993-1995	1994-1996	1995-1997	1996-1998	1997-1999
North Carolina	126,461 uninsured children at or below 200% FPL.	Based on Office of State Planning 1997 population data for children under age 19, distributed by age and income according to the 1995-1997 CPS, net of the number of children with Medicaid coverage in September 1997 (according to state Medicaid eligibility data) and the number with non-Medicaid insurance coverage (according to the March 1995-1997 CPS).	138,000 (16,200)	163,000 (23,400)	200,000 (28,300)	212,000 (29,300)	195,000 (27,800)
North Dakota	14,662 uninsured children.	Based on a Robert Wood Johnson Foundation Family Survey conducted in 1998.	10,000 (2,400)	10,000 (2,500)	15,000 (3,200)	20,000 (3,700)	19,000 (3,700)
Ohio	174,000 uninsured children below 150% FPL, of which 79,000 are potentially eligible for SCHIP and 95,000 are potentially eligible for Medicaid.	Based on the 1998 Ohio Family Health Survey, a telephone survey of 12,500 households, conducted from January to August 1998.	205,000 (25,600)	210,000 (28,900)	203,000 (29,700)	189,000 (28,700)	183,000 (28,000)
Oklahoma	124,123 uninsured children below 185% FPL, of which 83,148 are Medicaid eligible but not enrolled and 40,995 are eligible for SCHIP.	Based on March 1994-1996 CPS, adjusted for Medicaid underreporting and historical insurance coverage based on HCFA 2082 and Urban Institute data.	161,000 (23,200)	142,000 (21,300)	143,000 (21,200)	116,000 (18,800)	93,000 (17,100)
Oregon	79,099 uninsured children below 200% FPL, of which 22,662 are estimated SCHIP eligible.	Based on estimates of uninsured rates from the 1998 Oregon Population Survey, applied to population estimates from the Portland State University.	67,000 (15,800)	82,000 (17,200)	79,000 (17,200)	80,000 (17,000)	77,000 (16,700)
Pennsylvania	257,654 total uninsured children, of which 54,172 are potentially eligible for federally subsidized SCHIP.	Based on recalculation using rolling average of 1996-1998 CPS, which incorporated a "net income" test for Medicaid and SCHIP eligibility, revised estimates of Medicaid/SCHIP enrollment, and increased the age limit covered by Medicaid.	200,000 (26,300)	192,000 (27,500)	172,000 (26,500)	157,000 (25,100)	138,000 (23,900)

Table IX.1 *(continued)*

State	Baseline Estimate	Methodology	Current Population Survey (CPS) Estimates of the Uninsured Population Under Age 19 At or Below 200% of the Federal Poverty Level (FPL)				
			1993-1995	1994-1996	1995-1997	1996-1998	1997-1999
Rhode Island	14,000 uninsured children at or below 200% FPL.	Based on March 1997 CPS.	19,000 (9,000)	17,000 (4,700)	15,000 (4,200)	11,000 (3,700)	11,000 (3,800)
South Carolina	162,500 uninsured children below 150% FPL potentially eligible for SCHIP.	Based on the number already covered under SCHIP (104,000) plus the number who were potentially eligible as of July 1999 (58,500); the number of potential eligibles was derived by (1) calculating the percent uninsured (based on the 1995-1997 CPS adjusted upward for the standard error of the estimate); (2) multiplying this rate times the 2000 population projection for children under 175% FPL (the effective income threshold after disregards); and (3) subtracting the number of children added to Medicaid between the end of 1997 and June 1999 (since they would have been counted as uninsured in the 1995-1997 CPS and are now covered).	110,000 (18,500)	129,000 (22,700)	139,000 (24,600)	141,000 (24,600)	128,000 (23,500)
South Dakota	13,000 uninsured children under age 19 at or below 200% FPL.	Based on 1996-1998 CPS.	15,000 (2,900)	10,000 (2,600)	12,000 (2,900)	12,000 (2,900)	12,000 (3,000)
Tennessee	68,000 uninsured children.	Based on 1996 telephone survey of Tennesseans conducted by the Center for Business and Economic Research at the University of Tennessee.	115,000 (23,400)	166,000 (30,300)	165,000 (31,000)	139,000 (27,200)	75,000 (20,900)
Texas	75,000 uninsured children ages 16 to 18 who were potentially eligible for SCHIP.	Based on March 1999 CPS; potential SCHIP eligibility defined according to age (16 to 18 years), health insurance coverage, poverty level, and family characteristics. Includes only children living in TANF-type families with gross incomes between 76% and 100% FPL; or non-TANF-type families with gross incomes at or below 100% FPL. (TANF-type families are those that were headed by a single parent and had children; or those that had two parents present, both unemployed, and had children.)	1,031,000 (70,700)	1,074,000 (73,200)	1,034,000 (72,700)	1,084,000 (74,100)	1,040,000 (73,000)

Table IX.1 *(continued)*

State	Baseline Estimate	Methodology	Current Population Survey (CPS) Estimates of the Uninsured Population Under Age 19 At or Below 200% of the Federal Poverty Level (FPL)				
			1993-1995	1994-1996	1995-1997	1996-1998	1997-1999
Utah	62,659 total uninsured children, of which 30,000 are estimated to be SCHIP-eligible.	Based on 1996 Utah Health Status Survey. The survey estimated that 8.5% of Utah children 18 years and younger were uninsured. This figure was applied to population data obtained from the Governor's Office of Planning and Budget.	46,000 (9,000)	47,000 (9,300)	51,000 (9,700)	50,000 (9,600)	48,000 (9,400)
Vermont	6,047 uninsured children.	Based on the 1997 Vermont Family Health Insurance Survey, administered by the Vermont Banking, Insurance, Securities and Health Care Administration (BISHCA).	7,000 (2,300)	6,000 (2,300)	5,000 (2,000)	3,000 (1,600)	4,000 (1,800)
Virginia	State reported the targeted number of uninsured children to be served in FFY 1999 (36,340) through FFY 2001 (63,200) but did not report a baseline estimate of the number of uninsured children prior to SCHIP.	Did not report.	118,000 (25,100)	111,000 (25,600)	108,000 (26,300)	123,000 (27,600)	134,000 (29,100)
Washington	14,500 uninsured children eligible for SCHIP at the start of the program.	Based on the Office of Financial Management's 1998 Washington State Population Survey (WSPS), estimate of the number of uninsured children in households with incomes between 200% and 250% FPL at the time of the survey (March/April 1998), adjusted for growth in the child population between the WSPS and the start of the program (February 2000).	85,000 (21,200)	109,000 (25,400)	99,000 (25,200)	83,000 (22,200)	65,000 (19,700)
West Virginia	10,700 uninsured children between the ages of 1 and 18; another 13,000 children may have limited coverage (such as school insurance or catastrophic coverage).	Estimates by The Lewin Group, 1997 (method not specified).	45,000 (9,400)	29,000 (7,200)	26,000 (6,500)	25,000 (6,500)	30,000 (7,100)

Table IX.1 *(continued)*

			Current Population Survey (CPS) Estimates of the Uninsured Population Under Age 19 At or Below 200% of the Federal Poverty Level (FPL)				
State	Baseline Estimate	Methodology	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999
Wisconsin	54,000 uninsured children below 200% FPL, of which 23,000 are below 100% FPL and 31,000 are between 100% and 200% FPL.	Based on the 1997 and 1998 Wisconsin Family Health Survey, a year-round telephone survey, which measures the number of uninsured at a point in time.	71,000 (18,200)	62,000 (18,000)	54,000 (16,600)	46,000 (15,100)	66,000 (18,400)
Wyoming	38,920 total uninsured children, of which 11,442 are at or below 150% FPL.	Based on U.S. Census and GAO data, as derived by the Division of Economic Analysis of the Wyoming Department of Administration and Information.	15,000 (3,200)	15,000 (2,900)	14,000 (2,700)	13,000 (2,600)	12,000 (2,500)

SOURCE: Baseline Estimate: Mathematica Policy Research analysis of FFY 1998 Annual Reports and title XXI State Evaluations, Section 1.1 of the State Evaluation Framework.

CPS Estimates 1993-1995:	www.census.gov/hhes/hlthins/liuc95.html
CPS Estimates 1994-1996:	www.census/gov/hhes/hlthins/liuc96.html
CPS Estimates 1995-1997:	www.census.gov/hhes/hlthins/liuc97.html
CPS Estimates 1996-1998:	www.census.gov/hhes/hlthins/liuc98.html
CPS Estimates 1997-1999:	www.census.gov/hhes/hlthins/liuc99.html

NOTE: Standards errors in parentheses below CPS estimates.

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1. State Approaches to Measuring Progress

State approaches to measuring progress varied. The most common approaches were: (1) reporting of aggregate enrollment trends; (2) construction of a "penetration rate"; and (3) comparison of uninsured rates over time. Each approach has limitations, which are discussed below.

a. Aggregate Enrollment Levels

The simplest indicator of state efforts to reduce the number of uninsured children is a measure of aggregate enrollment in SCHIP. This method was used by 26 states.[3] However, because some children may have had other insurance coverage prior to enrolling in SCHIP, enrollment figures may overstate reductions in the number of uninsured children. Moreover, enrollment numbers alone do not indicate how a state is progressing relative to a baseline.

b. Penetration Rates

A second approach is to derive a penetration rate, by measuring enrollment in relation to a baseline estimate of the number of children potentially eligible for SCHIP. Sixteen states reported measuring their progress based on a penetration rate.[4] The penetration rates generally ranged from 30 to 50 percent, although some were quite a bit higher. The states commented that, as their enrollment continues to grow, their penetration rates should steadily increase as well.

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[3] The 26 states using this approach were: Alabama, Alaska, Arizona, Arkansas, Connecticut, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, Nebraska, New Hampshire, New Jersey, New York, North Dakota, Oklahoma, Tennessee, Utah, Vermont, Washington, and Wyoming.

[4] The 16 states using this approach were: California, Colorado, Delaware, District of Columbia, Georgia, Iowa, Michigan, Montana, New Mexico, Ohio, Oregon, South Carolina, South Dakota, Texas, West Virginia, and Wisconsin.

- California enrolled 178,725 children in the Healthy Families Program (HFP) during the first 18 months, representing 54 percent of all projected eligible uninsured children. The state attributed the relative speed of its progress to such eligibility simplification initiatives as the implementation of a mail-in application, a user-friendly four-page application, a single point-of-entry screening process, community-based outreach infrastructure, elimination of asset tests, use of 12-month continuous eligibility, and simplified documentation requirements. The state reported that crowd-out did not occur to any significant extent; only 3.7 percent of successful applicants had employer-sponsored insurance coverage in the 90-day period prior to application. Of these, 60 percent lost coverage due to loss of employment; 10 percent had employers that discontinued benefits; 5 percent reached the end of COBRA coverage; and the remaining 25 percent indicated other reasons for discontinuing coverage.

- Colorado reported that, as of September 30, 1999, it had covered 21,289 children, 31 percent of the state's estimated eligibles. This includes 5,528 children who transferred from the Colorado Child Health Plan (CCHP) when CHP+ was implemented in April 1998. CCHP was an outpatient-only program, so these children did not have creditable coverage prior to SCHIP.

- Delaware reported that SCHIP served 39 percent of the eligible children between 101 and 200 percent of poverty in FFY 1999 (including children who were eligible for, but not previously enrolled in, Medicaid).

- Georgia estimated that SCHIP covered about 40 percent of the eligible population at the end of FFY 1999; 47,584 children were enrolled in SCHIP, out of an estimated 119,558 eligible, uninsured children. The rate increased to 59 percent as of March 1, 2000, due to significant enrollment growth during the first two quarters of FFY 2000.

- Michigan estimated that it covered 68 percent of the eligible population as of September 1999, including about 27,000 children who enrolled in SCHIP and another 45,000 who applied for SCHIP as a result of the MIChild/Healthy Kids outreach campaign, but who were determined to be Medicaid-eligible. The penetration rate increased to 77 percent as of December 1999, due to accelerating enrollment.

- Ohio estimated there were 79,000 children eligible for M-SCHIP in 1998 (based on the Ohio Family Health Survey). Program penetration increased steadily from 28 percent (June 1998) to 43 percent (December 1998) and reached 59 percent by December 1999. The state set a goal of enrolling 75 percent of eligible children in its M-SCHIP program by December 2000.

- South Carolina enrolled approximately 69 percent of the eligible population in Partners for Healthy Children. This included not only 48,000 children enrolled in SCHIP, but also 64,000 added to Medicaid as a result of SCHIP.

- South Dakota estimated that the number of uninsured, low-income children declined from the baseline of 13,000 (in the 1996-1998 period), to 10,909 in 1999, and 6,943 in 2000. The state adjusted the baseline estimate by netting out the number of SCHIP enrollees. The reductions in the number of uninsured children were attributed to the increased enrollment of uninsured children in traditional Medicaid (excluding SSI children) and expanded coverage under M-SCHIP.

- Wisconsin reported that it reached 51 percent of uninsured children below 200 percent of poverty, as of February 2000. About 19,300 children were enrolled in BadgerCare and another 8,300 were enrolled in Medicaid, out of a total of 54,000 that were estimated to be uninsured at baseline. The program enrolled 42 percent of adults who were projected to be uninsured at baseline. The state reported that it exceeded its targets of enrolling 42 percent of eligible children and 29 percent of eligible adults.

Several caveats to this approach should be recognized. First, states varied in how they counted the numerator of the number of enrollees. Some used point-in-time estimates for enrollment, while others counted the number ever enrolled during the year (or some other reference period); in some cases, the metric was not clear. Second, the denominator, which reflects the projected number of eligibles, also varied widely across states (see Table IX.1). Finally, a major limitation of this approach—similar to the caveat about enrollment data in general—is that states often did not take into account the potential substitution of public for private insurance coverage. The numerator, therefore, may include some children who were previously insured. As a result, the penetration rate—relative to the previously uninsured target population—may, to some extent, be overstated.

c. Uninsured Rates Over Time

A third approach to measuring progress is to compare the number or rate of uninsured children over time. Seven states used this approach.[5] Comparisons were based on a broad measure of the target population (such as all children under 200 percent of poverty) or on a narrower segment of the target population, reflecting only those who were potentially eligible for

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[5] The seven states using this approach were: Florida, Maine, Missouri, North Carolina, Pennsylvania, Rhode Island, and Virginia.

SCHIP (that is, using a more precise income band and other adjustments).[6] Data from four states illustrate this approach to measuring change. None of the states, however, conducted significance testing to determine whether changes over time were statistically significant.

- Florida measured the number of uninsured children who were potentially eligible for SCHIP at two points in time (1993 and 1999) and calculated the change in SCHIP enrollment between June 30, 1998 and September 30, 1999. The state attributed 64 percent of the drop in the number of uninsured children to enrollment increases in SCHIP. The remaining differential was attributed to increases in employer-sponsored health insurance coverage and measurement differences between the two surveys. All the children who enrolled in SCHIP were uninsured at the time they applied for SCHIP; 11 percent, however, had employer-based coverage in the previous 12 months.

- Maine conducted a household survey at two points in time and found that the number of uninsured within the SCHIP income guidelines declined from 11,357 in 1998 to 7,158 in 1999.

- North Carolina estimated that the number of low-income, uninsured children declined 1.2 percentage points, from 15.7 percent in 1997 to 14.5 percent in 1999, while the uninsured rate for children between 201 and 300 percent of poverty increased 1.5 percentage points, from 15.7 percent to 17.2 percent. The state projects that if the children below 200 percent of poverty had followed the same trend, there would have been 22,542 more uninsured children in this group. The state concludes that the "gains have almost all been through the NC Health Choice program."

- Virginia compared uninsured estimates across three rounds of the Virginia Health Access Survey, which were conducted in 1993, 1996, and 1999. The percent of children who were uninsured declined from 14 percent in 1993, to 12 percent in 1996, to 10 percent 1999.

2. Effect of SCHIP Outreach on Traditional Medicaid Enrollment

In discussing their progress toward reducing the number of uninsured, low-income children, many states emphasized the "spillover effect" of SCHIP outreach on the enrollment of eligible children in Medicaid. This phenomenon is often called the "woodwork effect"—that is, where children who have long been eligible for Medicaid became enrolled as a direct result of new outreach and eligibility simplification initiatives under SCHIP. There is no single national source of data on the level of Medicaid enrollment that is attributable to SCHIP. However, some state evaluations reported on the extent of Medicaid enrollment due to SCHIP.

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[6] Potential eligibility can be simulated with CPS or state-specific survey data, but a typical limitation of any survey is that the income data are not nearly precise enough to capture the nuances of eligibility determination, such as the categories of income that are counted and any adjustments that are made for disregards.

States typically estimated the extent of Medicaid spillover using one of two methods: (1) estimating longitudinal Medicaid enrollment trends and attributing enrollment that was higher than expected to SCHIP; and (2) tracking applications to Medicaid that came through the SCHIP enrollment process.[7] The following examples illustrate the magnitude of Medicaid enrollment following the implementation of SCHIP. In some states, Medicaid enrollment attributable to SCHIP actually exceeded the level of SCHIP enrollment, indicating that SCHIP may be having a much more dramatic effect on reducing the number of low-income, uninsured children than would be reflected by SCHIP enrollment data alone.

- Arizona attributed its rapid acceleration in KidsCare and Medicaid enrollment to the effectiveness of its outreach efforts and the simplified "dual-eligibility process" that determines eligibility for both programs. Medicaid enrollment due to KidsCare outreach grew from 741 as of December 1, 1998, to 18,693 as of October 1, 1999. KidsCare enrollment was 21,256 as of October 1, 1999. Medicaid enrollment accounted for 47 percent of total enrollment due to KidsCare outreach efforts.
- California implemented a "single point of entry" for its Medicaid and SCHIP programs, enabling the state to direct eligible children to the Medicaid program. Between March 1999 and September 1999, the state directed more than 25,000 applications to Medicaid as a result of the combined outreach campaign. This represents about one in four applications to the SCHIP program during the seven-month period. What is not clear is how many of these applicants ultimately were enrolled in Medicaid.

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[7] We do not report state estimates that simply compare the number of children enrolled in Medicaid at a point-in-time before SCHIP with the number enrolled at a point-in-time after SCHIP because they do not take into account longitudinal trends that would have occurred in the absence of SCHIP.

- Florida reported that 85,888 children were enrolled in Medicaid through June 30, 1999, as a result of applications referred to Medicaid by the SCHIP enrollment process. About 28 percent of children who enrolled in Medicaid through the simplified application process were of Hispanic ethnicity. In the year prior to June 1998, child Medicaid enrollment had declined by 6.4 percent; as of September 30, 1999, child Medicaid enrollment was 15 percent higher than the previous June. Some of the increase is due to continuous eligibility. Nevertheless, the state concluded, "without CHIP, Medicaid rolls would continue to decline."

- Kansas estimated that 17,800 children had enrolled in Medicaid as of March 2000, as a result of the HealthWave (SCHIP) application process. This exceeded the number enrolled in SCHIP—16,040 as of March 2000. The state determined the number of Medicaid children enrolled as a result of SCHIP application and outreach efforts by cross-matching the Medicaid eligibility file with the HealthWave applications file (maintained by the enrollment contractor). Those that matched were considered to have entered Medicaid as a result of SCHIP.

- Kentucky estimated that 16,080 additional children enrolled in Medicaid during the quarter ending September 30, 1999, compared to the previous year. This reflects children who applied via a mail-in application, which did not exist prior to July 1, 1999. The state exceeded its goal of increasing Medicaid enrollment by 10,000 children.

- Maryland estimated that 16,000 children became eligible for Medicaid as a result of SCHIP outreach activities. This estimate is based on the increase in enrollment that would have been expected based on normal projected growth trends. (By comparison, 15,486 children were enrolled in Maryland's SCHIP program, as of September 30, 1999.)

- New Jersey estimated that two children enrolled in Medicaid for every three that enrolled in SCHIP. While 42,000 uninsured children were enrolled in SCHIP, another 22,133 were enrolled in traditional Medicaid as a result of the NJ KidCare publicity and outreach. This estimate was based on a longitudinal analysis of Medicaid enrollment, from January 1993 through July 1998. Rates of increase averaged 7 to 8 percent each April until 1998, when enrollment was 28 percent greater than the prior April; the state attributed the difference in enrollment growth to publicity and outreach under SCHIP.

Some states are developing the capacity to monitor the effects of SCHIP on Medicaid enrollment. Colorado, for example, reported that it plans to follow Medicaid applications that originated through the S-SCHIP program to track the number that enrolled in Medicaid. A cover sheet will be attached to each application referred to Medicaid; once a Medicaid eligibility determination is made, it will be returned to the S-SCHIP program.

C. CONCLUSION

State progress toward reducing the number of uninsured, low-income children is one of the most elusive outcomes to measure, due to the lack of precise, consistent, and timely data. Moreover, by March 31, 2000, when states were required to submit their evaluations, many states had been operational for only 18 to 24 months, further challenging states' efforts to document their progress. To facilitate the tracking of state progress, CMS required each state to derive a baseline estimate of the number of uninsured, low-income children in the target population prior to the implementation of SCHIP. Most states used the CPS, despite the widely acknowledged limitations for producing state-level estimates.

State approaches to measuring progress varied and each approach has important caveats. The simplest indicator of state efforts—used by 26 states—is a measure of aggregate enrollment in SCHIP. Because some children may have had other insurance coverage prior to enrolling in SCHIP, enrollment figures may overstate reductions in the number of uninsured children.

Sixteen states derived a penetration rate, measuring enrollment in relation to their baseline uninsured estimates. The penetration rates generally ranged from 30 to 50 percent. However, the methods of calculating penetration rates varied among the states.

Seven states compared the number or rate of uninsured children over time. None of the states, however, conducted significance testing to determine whether changes over time were statistically significant.

In discussing their progress toward reducing the number of uninsured, low-income children, many states emphasized the spillover effect of SCHIP outreach and eligibility simplifications on the enrollment of eligible children in Medicaid. Some states reported that Medicaid enrollment attributable to SCHIP actually exceeded the level of SCHIP enrollment, indicating that SCHIP may be having a much more dramatic effect on reducing the number of low-income, uninsured children than would be reflected by SCHIP enrollment patterns alone.

X. STATE RECOMMENDATIONS FOR IMPROVING TITLE XXI

Congress mandated that the state evaluations include recommendations for improving SCHIP, and virtually all states suggested ways in which the program could be improved. States offered a wide range of recommendations with some states focusing on a single priority, while others specified multiple priorities. It should be noted, however, that priorities mentioned by one state could be important to other states even though the issues were not raised in their state evaluations.

This chapter synthesizes the states' comments, and the recommendations reflect several basic themes:[1]

- Improve coverage of uninsured low-income children by extending coverage to certain excluded populations (such as children of public employees), by covering uninsured parents, by increasing options for buying into employer-sponsored insurance (ESI), and by easing provisions related to crowd-out
- Improve the financing and administration of the program by eliminating or modifying the 10 percent administrative cap, by allowing a longer time frame for spending the title XXI allotment, and by improving technical assistance and coordination among Federal programs (for example, by facilitating outreach through other public assistance programs or conducting national media campaigns)
- Maintain flexibility for separate programs, rather than imposing Medicaid-like rules and regulations

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[1] It should be noted that the state evaluations were submitted within a few months of the release of the proposed rule for the implementation of SCHIP (*Federal Register*, November 1, 1999). This chapter reflects state recommendations, as presented in their state evaluations. Subsequently, CMS issued the final rule (*Federal Register*, January 11, 2001) and revisions to the final rule (*Federal Register*, June 25, 2001). In addition, CMS issued guidance regarding SCHIP 1115 demonstrations on August 4, 2001, under the Health Insurance Flexibility and Accountability (HIFA) Initiative, which superceded the previous guidance. Where applicable, this chapter identifies statutory or regulatory changes that have occurred since the state evaluations were submitted.

A. RECOMMENDATIONS TO IMPROVE COVERAGE

1. Expand Coverage for Children of Public Employees

One common recommendation made by states was to allow states with S-SCHIP programs to cover children of public employees (Alabama, Arizona, Arkansas, Florida, Georgia, Iowa, Kansas, Louisiana, Maine, and Ohio). The title XXI statute explicitly excluded coverage of "a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State" (section 2110(b)(2)(B)). States viewed this exclusion as inequitable to children in families where one of the parents is employed by the state:[2]

- Alabama: "We have many state employees whose income is well within the ALL Kids guidelines and they are not able to afford the $164 per month premiums for family coverage."
- Louisiana: "If a Medicaid expansion program is the chosen option, then these children would be eligible.... (We) recommend that this exclusion be removed so that this population would qualify for both options."
- Maine: "The state recognizes the importance of preventing crowd-out. However, we are concerned that children of public employees are treated differently than other children in this regard. We recommend that state crowd-out strategies, such as waiting periods, apply to all children who are applying regardless of the families' source of employment."

2. Allow Coverage of Uninsured Parents

Title XXI allowed states to purchase family coverage through group health plans if such coverage was cost-effective relative to coverage of children only. States expressed concern that this requirement posed a barrier to covering parents and, therefore, recommended that title XXI be amended to allow uninsured parents to qualify and enroll in SCHIP. Several states (California, Illinois, Kentucky, Nevada, Rhode Island, and Wisconsin) noted that expanding coverage to uninsured parents is necessary if SCHIP programs are to meet their goals of reaching uninsured children.[3]

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[2] The January 11, 2001 final rule clarified that children of public employees may be covered under SCHIP if the employer contribution is no more than a nominal contribution of $10 per family per month. Moreover, the final rule made explicit that the definition of a state health benefits plan excludes "separately run county, city, or other public agency plans that receive no State contribution toward the cost of coverage and in which no State employees participate."

- Wisconsin officials noted that they view such coverage "as a matter of good public policy and for practical purposes: more eligible children are enrolled when a public health program is offered to the entire family, rather than children alone."
- Rhode Island also "wants to cover adults under its CHIP program. The State believes firmly that comprehensive quality care cannot be accomplished to meet identified needs of targeted, low-income children until this is accomplished."

3. Allow Coverage of Other Populations

Several states commented that specific populations were excluded from coverage under SCHIP, and recommended that CMS modify the treatment of these groups. For example:

- Florida and Minnesota suggested allowing coverage of noncitizen children who do not currently qualify for SCHIP. As Minnesota wrote, "states cannot effectively cover all children as long as the citizenship barriers are in place" in both the Medicaid and SCHIP programs.
- Montana requested that children residing in Institutions for Mental Diseases (IMD) at the time of eligibility redetermination be allowed to remain on SCHIP.

4. Remove Barriers to Coordinating with Employer-Sponsored Insurance

States expressed the need for increased flexibility to coordinate with employer-sponsored insurance (ESI) coverage (Arizona, California, Florida, Iowa, Kansas, Kentucky, Minnesota,

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[3] On July 7, 2000, CMS issued guidance to states on using SCHIP 1115 demonstration authority as a mechanism to access SCHIP funds to cover adults. CMS issued additional guidance on August 4, 2001, under the HIFA initiative, which superceded the previous guidance. To date, CMS has approved SCHIP 1115 demonstrations in four states—Minnesota, New Jersey, Rhode Island, and Wisconsin—to allow use of enhanced Federal matching funds to cover parents and/or pregnant women under SCHIP. CMS has also approved HIFA demonstrations in five states—Arizona, California, Illinois, New Mexico, and Oregon—that allows these states to use title XXI funding to cover adults.

Ohio, Oregon, and Washington). As of March 31, 2000, two states had developed premium assistance initiatives[4]:

- Massachusetts offered a Premium Assistance option to families that had access to ESI coverage through an employer. The employer must contribute at least 50 percent of the cost and must meet the benchmark benefit level to qualify for coverage under title XXI. Family premiums generally did not exceed $10 per child or $30 per family per month. The state paid the cost sharing for well-child visits and for out-of-pocket expenses exceeding 5 percent of income.
- Wisconsin developed the BadgerCare Health Insurance Premium Payment (HIPP) program to help families purchase ESI coverage, provided they have not had employer-sponsored group coverage in the previous six months and that the employer paid at least 60 percent but less than 80 percent of the premium share. Employer verification of insurance coverage and determination of the cost-effectiveness of subsidizing ESI coverage through BadgerCare were routine components of the Medicaid/SCHIP eligibility determination process.

Other states were interested in following their lead but expressed concerns about the requirements imposed either under statute or as a matter of Federal policy. The requirements were not viewed as "employer- or insurer-friendly" (Florida), and they were considered more restrictive than the employer buy-in requirements under title XIX (Kansas). States cited a variety of barriers to coordination with ESI coverage, including requirements for benefits, premiums, cost sharing, and waiting periods.

- Florida, Maryland, and Wisconsin reported that the requirement that employers share at least 60 percent of the premium cost was too stringent. Maryland conducted a survey of employers and found that the average employer contribution was less than 60 percent. Maryland's new premium assistance program requires a minimum employer contribution of 50 percent. Wisconsin recommended that the primary criterion be cost effectiveness relative to other SCHIP coverage, without specifying a minimum percentage contribution.[5]

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[4] Illinois reported that it offered a premium assistance program; however, it is a state-funded program and not offered through SCHIP. The KidCare Rebate program provides support to low-income families (between 133 and 185 percent of poverty) who have "acted prudently" and purchased coverage for their children. Families received $75 per month per child toward the purchase of private insurance. The program offered families a choice of health plans that were not government operated. According to the state, "Some families with uninsured children who would otherwise be eligible for KidCare Share or Premium choose to enroll their kids in private insurance with the assistance of KidCare Rebate." As of April 1, 2000, about 3,200 children were enrolled in this state-only program.

- Utah and Washington recommended that children be made eligible for premium assistance without having to be uninsured for six months. This requirement can introduce an inequity for families who have been struggling to pay the premium.
- Arizona noted that unique SCHIP protections mandated in the title XXI statute (such as no cost sharing for preventive care and a five percent cap on total cost sharing) make coordination with employer-sponsored insurance challenging and impose additional administrative costs on the state and on providers.[6]

5. Ease Provisions Related to Crowd-Out

Six states (Connecticut, New Hampshire, South Carolina, Utah, Washington, and Wisconsin) reported that anti-crowd-out provisions are counterproductive to the goal of providing seamless coverage for low-income children. Connecticut, for example, was opposed to the minimum six-month waiting period for ESI premium assistance, and suggested reducing the waiting period or designing other strategies to avoid crowd-out. South Carolina also was opposed to anti-crowd-out requirements because they may discriminate against low-income families (especially those below 150 percent of poverty) who have struggled to provide health insurance coverage to their children. The state was concerned that families may drop coverage to be eligible for SCHIP, and then third-party resources would be lost. South Carolina recommended allowing families to retain such coverage and permitting the state to coordinate SCHIP coverage with other third parties.

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[5] The final rule, issued January 11, 2001, eased the requirements for employer contributions. States no longer have to demonstrate a 60 percent employer contribution. They do have to indicate what the employer contribution is and provide evidence that the premium assistance program is cost-effective.

[6] The final rule, issued January 11, 2001, eased the cost-sharing requirements for adults covered under premium assistance programs. SCHIP cost-sharing requirements only apply to children.

B. RECOMMENDATIONS TO IMPROVE FINANCING AND ADMINISTRATION

1. Eliminate or Modify the 10 Percent Administrative Cap

Twenty-one states commented that the 10 percent administrative cap posed significant limitations on program design, implementation, and expansion (Arizona, California, Colorado, Connecticut, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Michigan, Montana, New Hampshire, New Jersey, New York, North Carolina, Vermont, and Washington).[7] States recognized that Congress intended to devote title XXI funds to purchase child health insurance and to minimize administrative expenses; North Carolina noted that this was a "laudable goal," but "unrealistic."[8]

Some states indicated that the cap limited their ability to conduct outreach and enrollment activities to make families aware of SCHIP, help them apply, determine their eligibility, and, ultimately, get them services. Arizona and Connecticut suggested that the 10 percent administrative cap limited evaluation. The limits were reported to be particularly difficult for states that were not able to cover a large number of children under SCHIP, since access to administrative funds was tied to expenditures on child health assistance.

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[7] Some states, in contrast, reported that the 10 percent cap had no effect on program design or else they relied on other funding sources to supplement the administrative funds allowed under title XXI. Many states used state funds to support outreach efforts under SCHIP. Other states subsidized labor costs, systems development, supplies, printing, and mailing, among other expenses.

[8] Although many states expressed concerns about the 10 percent cap on administrative expenses, few had reached or exceeded the cap. Nevertheless, Congress eased certain restrictions on spending that applies to the 10 percent cap, such as excluding costs incurred during a period of presumptive eligibility in which the child is later found ineligible for SCHIP. Moreover, states that did not spend all of their FFY 1998 allotment will be able to spend up to 10 percent of their retained funding on outreach, without those outreach expenditures being applied against the states' 10 percent fiscal year limit.

Several comments focused on the inequities faced by S-SCHIP programs because, unlike M-SCHIP programs, they cannot obtain matching funds for SCHIP administrative expenses under title XIX. They recommended expanding the cap to minimize disincentives to states that preferred to develop S-SCHIP programs. Several states (such as Idaho, Indiana, and Nebraska) had been interested in designing an S-SCHIP program but did not pursue that option (at least initially), because they thought it would not be possible to design and operate such a program within the 10 percent cap.

State recommendations ranged from outright elimination of the cap to more targeted modifications.

- New Hampshire recommended lifting the 10 percent cap to allow states to staff SCHIP programs adequately and make system improvements with the goal of "having the 'old' Medicaid program look more like the 'new' CHIP program."
- New York suggested redefining the expenditures that were subject to the 10 percent cap, requesting that the cost of premiums be excluded for children who were presumptively eligible but who were later found to be ineligible.[9]
- Nevada offered several suggestions for relieving the financial pressure on states, including raising the cap from 10 to 15 percent, removing outreach and marketing expenses and the costs of external quality review from the cap, and allowing states to draw up to 10 percent of the unused portion of the allotment for administrative expenses.
- Indiana, Iowa, and Michigan suggested removing outreach activities from the cap. According to Michigan, the cap "is a structural barrier to an effective CHIP outreach

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[9] The final SCHIP regulation incorporated this modification.

> program... A solution would be legislation that distinguishes outreach activity from activities that administer the program."[10]

States also recommended that special allowances be made to help states during the start-up period of new SCHIP programs or new components:

- Maryland expressed concern that the 10 percent cap would impose financial constraints in setting up a unit to administer its new premium assistance program. Texas also expressed concern about the effect of the cap on the design and implementation of its new S-SCHIP program.
- California and Colorado recommended that expenditures be permitted to exceed the 10 percent cap during program start-up (such as the first three years of the program), while Washington recommended that all up-front administrative costs be funded through Federal matching dollars.
- Kansas suggested that the 10 percent cap be based on the state allocation or some other amount to allow for start-up expenses before premiums are paid on behalf of eligible children.

2. Extend the Deadline for Spending the SCHIP Allotment

At the time states submitted their evaluations in March 2000, the deadline for spending their FFY 1998 SCHIP allotment was approaching.[11] Some states recommended that they be allowed to keep their unspent SCHIP allotments for more than three years. Maryland and New Jersey, for example, suggested that the reallocation take place after five years rather than three years, to allow states to cover more uninsured individuals (including uninsured parents).

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[10] Congress enacted the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) in December 2000, which outlined the process for reallocating unspent FFY 1998 and 1999 SCHIP allotments. BIPA included a provision for states that would be retaining FFY 1998 funds (that is, states that did not fully spend their allotments) to allow them to spend up to 10 percent of their retained funds on outreach. These expenditures were not subject to the 10 percent administrative cap.

[11] CMS issued a notice in the June 21, 2001 *Federal Register*, specifying the "continued availability" of unexpended FFY 1998 funds and the amount of funds to be redistributed to states that spent all of their FFY 1998 allotment. The 39 states that did not spend all of their FFY 1998 title XXI allotment were permitted to retain $1.3 billion of the $2.0 billion that was not spent. The remaining $0.7 billion was reallocated to the 12 states that spent their allotment as well as the U.S. territories and Puerto Rico. States were given until September 30, 2002, to spend the redistributed and retained funds.

Oklahoma recommended that states be allowed to spend their allotment to cover uninsured children who were newly enrolled in Medicaid. According to Oklahoma, the allotments were based upon the number of uninsured children below 200 percent of poverty, including children who were Medicaid-eligible. The state indicated that this penalized states whose uninsured populations were primarily comprised of Medicaid-eligible children. While SCHIP outreach may help identify these children, they are required to be enrolled in Medicaid. Therefore, the state may not be able to spend its SCHIP allotment. Oklahoma recommended that states be allowed to use SCHIP funds to cover all currently uninsured children, regardless of which program they qualify for. Oklahoma concluded that states would have an incentive to adopt more effective outreach programs if the SCHIP allotment could be applied to covering uninsured children who were found eligible for traditional Medicaid.

Several states that had exhausted their FFY 1998 allotments were seeking opportunities to increase their funding to continue serving uninsured children. New York, for example, recommended that "those states that exceed their approved allotments be given the necessary funding to sustain their successful programs." Indiana suggested that states with S-SCHIP programs be allowed to access Federal Medicaid funds once their SCHIP allocation has been exhausted (similar to M-SCHIP programs).

3. Improve Technical Assistance and Coordination Among Federal Programs

Many states cited the need for additional coordination at the Federal level to assist states with outreach and enrollment. They offered examples where Federal leadership would be helpful in resolving issues:

- Colorado cited the importance of resolving the confidentiality issues in working with the National School Lunch Program (NSLP).[12]
- North Dakota called for Federal involvement in working with the U.S. Postal Service to allow school districts to send out information about SCHIP through their bulk mail permit although it may identify insurance companies participating in the program.
- Indiana recommended increased coordination of multiple funding sources (such as the Special Supplemental Food Program for Women, Infants, and Children [WIC], maternal and child health [MCH], and the NSLP), to avoid duplication and maximize resources. Areas for coordination include standardization of eligibility and reimbursement guidelines and assistance with data sharing.

In addition to improved coordination at the Federal level, several states called for additional technical assistance from the Federal government:

- Colorado recommended Federal leadership in developing and disseminating outreach materials and developing a clearinghouse for state-based information on activities that demonstrate best practices.
- Kentucky recommended Federal leadership in developing approaches to measuring outcomes and quality of care (similar to what has been done for outreach and eligibility simplification).
- The District of Columbia requested assistance in developing more precise estimates of the number of uninsured children who are eligible for SCHIP.

Idaho and North Carolina emphasized the need for Federal leadership in undertaking aggressive marketing through national media campaigns, especially since media markets may cross over state boundaries. Idaho indicated that it cannot use state dollars to purchase media coverage in out-of-state markets. North Carolina suggested that the Federal government explore "product placement" within national television programs (such as "ER" or "Chicago Hope") to highlight why it is important to have health insurance for children.

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[12] Considerable progress has been made in this area as a result of Federal interagency efforts. A new law became effective October 1, 2000, allowing NSLP and SCHIP authorities to share information.

C. RECOMMENDATIONS TO MAINTAIN OR INCREASE FLEXIBILITY

1. Reduce Requirements for SCHIP Programs

In the view of 13 states—Florida, Kentucky, Massachusetts, Minnesota, Missouri, New York, North Carolina, Ohio, Pennsylvania, Utah, Vermont, Virginia, and Wyoming—the title XXI program has taken on a new direction, one that signals less flexibility in designing and implementing SCHIP programs. These states, almost all of which have developed S-SCHIP programs, were concerned that the proposed SCHIP regulations would add to the administrative burden, stifle creativity, and increase tensions between the Federal government and states. They commented that the SCHIP regulations appeared to be "patterned after Medicaid" (New York) and reflected a "Medicaid mindset" (Ohio). Florida cited three examples of areas where additional requirements not specified in the title XXI statute have been proposed: (1) lowering cost-sharing levels based on a family's income;[13] (2) exempting American Indian children from cost sharing; and (3) requiring states to implement the Consumer Bill of Rights and Responsibilities (CBRR).[14] According to Massachusetts' state evaluation:

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[13] The revised final rule issued June 25, 2001, revised the cost-sharing policy. The previous policy had instituted per-service caps on cost sharing and a maximum allowable cost sharing of 2.5 percent of family income for families below 150 percent of poverty. The new policy retained the per-service cost-sharing caps for families below 150 percent of poverty; however, the maximum allowable cost sharing was revised to be 5 percent of family income regardless of income level.

[14] States were not required to implement the CBRR under their SCHIP programs. However, the SCHIP regulations did mirror some of the expectations identified in the CBRR. The revised final rule issued June 25, 2001, provided greater flexibility in the area of applicant and enrollee protections.

> When title XXI was authorized, Massachusetts had already given thought to expanding access and was in the process of moving forward. With the new options available under title XXI, the state was able to pursue these plans even more vigorously. For states not already planning an expansion it is clear that title XXI provided the impetus to move in the direction of expanding coverage to children. In addition, the political dynamic encouraged states to take on the challenge of moving forward.... In thinking about the future of title XXI it is important that the flexibility that states have had to design their own programs be maintained. We have concern, however, that the direction of the proposed title XXI regulations would remove some of this flexibility.

Some states perceived a bias against S-SCHIP programs and recommended that certain restrictions be reduced. Five states (California, Florida, Kansas, North Carolina, and Washington) recommended that S-SCHIP programs be allowed to participate in the Federal Vaccines for Children (VFC) program, as M-SCHIP programs are allowed to participate. Several states also raised concerns about the policy prohibiting S-SCHIP programs from requiring applicants to submit their Social Security number (SSN). They noted that the SSN facilitated matching against Medicaid eligibility records and verifying income reporting.[15]

Other recommendations included allowing S-SCHIP programs to participate in the drug rebate program (again like M-SCHIP programs); compensating states for lost revenues due to prohibitions against cost sharing for American Indian children under SCHIP; and giving states the flexibility to change funding sources for the state share of the match without having to amend their state plan.

S-SCHIP programs were given greater flexibility than M-SCHIP programs in deciding who can determine eligibility. Only state employees are permitted to determine Medicaid eligibility (and, by extension, M-SCHIP eligibility), whereas S-SCHIP programs can rely on employees at health centers, day care centers, schools, and other settings. Illinois advocated that M-SCHIP programs be allowed greater flexibility in making eligibility determinations, similar to the options offered to S-SCHIP programs.

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[15] The revised final rule issued June 25, 2001, gives states the option of requiring SSNs for SCHIP applicants.

2. Increase Flexibility Regarding Cost-Sharing

Several states recommended that CMS provide increased flexibility to require cost sharing for specific services or populations and not cap cost sharing for higher-income families. Several objectives motivated their recommendations: to ease administrative complexity, to increase parental responsibility, to control program costs, or to emulate private insurance practices. In particular, several states would like the flexibility to require cost sharing of SCHIP families whose income is above 100 percent of poverty rather than 150 percent (Alaska and Arkansas) or to implement targeted copayments for services such as inappropriate emergency room use (Ohio). Other states recommended refinements to cost-sharing policies for SCHIP families above 150 percent of poverty:

- New Jersey requested that CMS eliminate the 5 percent cost-sharing cap for families with income above 200 percent of poverty because they have found that it is difficult to monitor the total income of higher-income families.
- Montana is opposed to cost-sharing provisions that would deviate from typical private health insurance practices, such as allowing only one copayment during a single office visit rather than on a per-service basis; prohibiting cost sharing for laboratory tests and preventive or diagnostic dental services; and allowing noncovered services to be counted against the cost-sharing limit for children with chronic conditions.
- Idaho had proposed a graduated voucher system to help families "become self-reliant from the CHIP program" as their income increases, but this approach was rejected by CMS. The state recommended that the Federal government review options that states could use to foster increasing parental responsibility for the cost of health insurance as their income increases.

3. Increase Flexibility in the Definition of Creditable Coverage

Several states also requested additional flexibility in defining "creditable coverage" under title XXI. Washington found the term confusing and recommended that CMS simplify the definition. Other states expressed concern that underinsured children are not eligible for SCHIP.

- Iowa, New Hampshire, and New York questioned the exclusion of children with catastrophic, high deductible insurance who are considered to have creditable coverage and, therefore, are not eligible for SCHIP. As New Hampshire noted, "These policies offer little value to families with children since they do [not] cover preventive and routine care. Yet these families are penalized, while families who have been willing to take a risk in being uninsured qualify. It would be helpful to allow flexibility in the CHIP funding to provide supplemental benefits to these children."
- California suggested that families without insurance coverage for dental or vision services be allowed to buy into SCHIP for those services.

D. CONCLUSION

As mandated by Congress, the state evaluations presented numerous recommendations for improving title XXI. Four recommendations were mentioned most frequently in the state evaluations. The most common concern among states was that the 10 percent administrative cap constrained many states' efforts to conduct outreach, particularly among states with S-SCHIP programs that cannot obtain regular Medicaid matching funds for excess expenditures. States offered a number of suggestions, ranging from changing the way the cap is calculated, to removing outreach costs from the cap, and raising the level of the cap.

Second, many states perceived a shift in the policy direction of title XXI at the Federal level, signaling less flexibility, particularly for S-SCHIP programs. This concern was motivated by the perception that the SCHIP regulations reflected a Medicaid orientation, which could add to the costs and limit creativity among S-SCHIP programs. Specifically, states expressed concerns about the more stringent limits on cost sharing for lower-income families, requirements for fraud detection, and requirements to implement consumer protections in managed care programs. A number of these concerns were addressed by the revised final rule issued June 25, 2001.

Third, many states reported that they faced significant barriers in coordinating with employer-sponsored insurance, an important vehicle for expanding insurance coverage among low-income children and for avoiding crowd-out of private insurance coverage. Areas for improvement included reducing requirements for employer contributions, minimizing waiting periods without health insurance coverage, and easing requirements for health plans (such as benefits and cost-sharing limits).

Fourth, some states suggested that they cannot succeed in reducing the number of uninsured low-income children until coverage is expanded to certain omitted groups, such as children of public employees and uninsured parents. Some states believe that uninsured children will not gain coverage until their parents are covered as well.

As the SCHIP program enters its sixth year, states will continue to strive to meet the goal of reducing the number of uninsured low-income children. These recommendations reflect state priorities for improving the SCHIP program.

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APPENDIX A

PROFILE OF SCHIP PROGRAMS IN THE U.S. TERRITORIES

Title XXI provides funding not only to the 50 states and the District of Columbia, but to the five U.S. territories—American Samoa, Commonwealth of Northern Mariana Islands (CNMI), Guam, Puerto Rico, and the U.S. Virgin Islands (USVI) as well.

This appendix provides information on the territories' use of title XXI funding, as reported in the *Framework for Territory Evaluations of Children's Health Insurance Plans Under Title XXI of the Social Security Act.* A workgroup of representatives from the territories, CMS, HRSA, and MPR created the territory evaluation framework by modifying the state evaluation framework to better reflect the territories' unique use of title XXI funding. The territories completed their evaluations for the period October 1, 1997 through September 31, 1999. All territories except Puerto Rico submitted evaluations; because Puerto Rico has not yet submitted its SCHIP evaluation, this appendix provides information only for American Samoa, CNMI, Guam, and USVI, unless otherwise noted.

A. FACTORS AFFECTING THE TERRITORIES' SCHIP PROGRAMS

The territories identified several factors that affect their use of title XXI funding: (1) the level of Federal funding the territories receive for their Medicaid and SCHIP programs; (2) the effect of welfare reform on the number of enrollees eligible for Federal funding; (3) the role of increased immigration from neighboring nations; and (4) other economic factors, such as cash-flow problems and economic slowdowns. This section discusses how each of these factors affects the financial viability of the territories' Medicaid programs.

1. Level of Funding

The level of Federal Medicaid funding for the territories' programs differs from that provided to the 50 states or the District of Columbia. Sections 1905(b)(2) and 1101(a)(8)(A) of the Social Security Act limit the territories to a Federal Medical Assistance Percentage (FMAP) of 50 percent for Medicaid, regardless of the territories' per capita income.[1] The matching rate for the territories is not calculated on the basis of per capita income, as it is in the 50 states and the District of Columbia; instead, it is calculated as a proportion of the medical component of the Consumer Price Index. Additionally, each of the territories' total available Federal Medicaid funding is subject to congressionally-mandated spending caps, unlike the states and the District of Columbia, where no spending limits exist as long as states contribute their share of matching funds (U.S. House of Representatives 2000). When a territory reaches the mandated Medicaid funding cap, it pays for the program costs using unmatched territorial dollars.

The four territories reporting indicated that they used local funds to pay for Medicaid costs they incurred after the Federal cap was exhausted. Guam and USVI described the resulting financial impact:

- In Guam, the 1998 Medicaid cap was $5.1 million. Total program costs that year totaled $10.9 million, with Guam contributing $5.8 million—more than 53 percent of the program cost.
- The Federal share of the USVI Medicaid program was capped at $5.4 million for FFY 1999. Total program costs that year totaled $13.4 million, with USVI contributing roughly $8.0 million—more than 60 percent of the program cost.

Because of the limitation on available Federal funding, the territories reported that they often rationed or limited services because they did not have enough resources to provide services to all those in need.

- In American Samoa, when Federal funds were exhausted, the territory restricted the benefit package: EPSDT services were not provided, vaccines were not purchased, and treatment of special health care needs (such as asthma, diabetes, and mental illness) was limited.

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[1] Federal law limits the FMAP for states to a 50 percent minimum and an 83 percent maximum. In 2000, the FMAP ranged from 50 percent in 10 states to 77.80 in Mississippi; it averaged 57 percent overall (Health Care Financing Administration 2000).

- Due to the Federal spending cap, CNMI limited the provision of enabling services. If possible, they used other sources of Federal dollars, such as title V maternal and child health (MCH) funds, to provide these services.
- USVI reported that they ran a "bare-bones" program, concentrating on acute care versus preventive care.

The title XXI legislation has provided the territories with an opportunity to receive additional and enhanced funding to support the provision of children's health services. For SCHIP, the territories' enhanced FMAP is 65 percent. Each territory's SCHIP allotment is not calculated in the same way as it is in the states and District of Columbia. The territories, as a whole, receive 0.25 percent of the total SCHIP base appropriation for each year, and then each territory receives a percentage of this amount: Puerto Rico, 91.6 percent; Guam, 3.5 percent; USVI, 2.6 percent; American Samoa, 1.2 percent; and CNMI, 1.1 percent (U.S. House of Representatives 2000). The SCHIP allotments for FFY 1998 through 2000 were as follows:

Territory	FFY 1998 Title XXI Allotment	FFY 1999 Title XXI Allotment	FFY 2000 Title XXI Allotment
Total	$10,737,501	$42,687,501	$44,887,501
American Samoa	$128,850	$512,250	$538,650
CNMI	$118,113	$469,563	$493,763
Guam	$375,813	$1,494,063	$1,571,063
Puerto Rico	$9,835,550	$39,101,750	$41,116,950
USVI	$279,175	$1,109,875	$1,167,075

SOURCE: *Federal Register,* vol. 65, no. 101, May 24, 2000.

Although the territories could use the SCHIP funds to expand eligibility overall, CMS gave territories the option of using SCHIP dollars for children who otherwise would be eligible for Medicaid benefits if Federal Medicaid funding had not been exhausted. The territories may only access the SCHIP funds to cover Medicaid costs when the Federal Medicaid caps are met.

American Samoa, CNMI, Guam, and the USVI decided to use SCHIP funds to pay for services provided to Medicaid children rather than expand eligibility. Puerto Rico opted to expand eligibility using an M-SCHIP to cover children between 100 and 200 percent of poverty. While CMS allowed the territories to use title XXI funding to supplement available Medicaid funding for children, the territories reported that Federal funding was still insufficient to cover all those who need assistance.

- American Samoa reported that SCHIP funds were used primarily to reimburse the costs of Medicaid children receiving specialized services off the island. SCHIP dollars freed up territory funds, allowing for increased access to dental services, immunizations, mental health services, and off-island referrals. Nevertheless, the territory reported that approximately 5,000 children (primarily adolescents and children with special needs) were not receiving health care.
- According to USVI, the congressional limitation on Medicaid funding prevented them from setting the income-eligibility threshold at the poverty levels used in the states to determine Medicaid eligibility. If the USVI were to use the FPL guidelines, they anticipate that Medicaid enrollment would double in size.

2. Impact of Welfare Reform

CNMI, Guam, and USVI also identified welfare reform legislation as having an impact on their SCHIP programs. Welfare reform legislation mandates that individuals who are not U.S. citizens or qualified aliens are ineligible for Federally funded services through public assistance programs such as Medicaid or SCHIP. As a result, the territories used territory-only funds to pay for health services provided to individuals ineligible for public assistance programs because of their immigration status.

- Prior to welfare reform, families and individuals who migrated to Guam received Medicaid if needed. After welfare reform, the territory removed these individuals from the Medicaid rolls and covered them under programs funded entirely by the territory.

- USVI indicated that welfare reform affected its Medicaid budget in another manner. The money allocated by the Federal government to facilitate welfare reform ($176,000) in USVI was counted against the Medicaid cap, so the territory had fewer Medicaid dollars for health care services in that year.

3. Role of Immigration

American Samoa, CNMI, and USVI reported that immigration to the territories continues to increase, causing an increase in the demand for medical services; yet welfare reform restricts Federally funded coverage only to U.S. citizens and qualified aliens. As a result, the territories found themselves further stretching territory-only funds to provide medical coverage to new immigrants.

- At the current population growth rates, American Samoa reported that its population will double in 15 to 20 years. Immigration and high birth rates are driving this growth, which is stretching the resources of the island. Immigrants can receive only territory-funded services. While their children may be eligible for Medicaid/SCHIP if they are born in American Samoa, there are not enough Federal funds to cover them.
- CNMI faces an influx of immigrants from the Freely Associated States (FAS), but welfare reform prohibits CNMI from receiving Federal funds to cover these immigrants. Instead, CNMI uses its limited medical and economic resources to cover the immigrants not eligible to receive Federally matched funds.
- USVI reported that many illegal immigrants come to the island to deliver their infants on American shores. The women typically do not have prenatal care and may have sick infants. The territory uses its own funds to pay for the services provided to these women and infants.

4. Other Economic Factors

In addition to funding levels, welfare reform, and increased immigration, American Samoa and CNMI pointed to other economic factors affecting their Medicaid programs and ability to access title XXI funding.

- American Samoa reported that the territory was experiencing a cash-flow problem that delayed its payments for the 50-percent Medicaid match, social security contributions, payroll deductions for bank loans, retirement, and insurances. This, in turn, impacted its ability to access its SCHIP funds.
- CNMI relied on tourism, the garment industry, and construction industries to generate its revenues. Economic hardship in Asia affected these revenues, thus decreasing the territory-only funds available to pay for medical and social services.

B. PROGRAM STRUCTURE

The territories' Medicaid programs had eligibility requirements, benefits, and delivery systems that differed from those in the states and the District of Columbia. Differences arose, in part, because of variations in the rules and regulations governing the territories' programs (U.S. House of Representatives 2000). First, territories were not mandated to provide coverage to the same eligibility groups as state Medicaid programs, such as poverty-related pregnant women and children. Second, territories used different income and asset tests than state Medicaid programs. Third, due to funding caps, CMS was more flexible in reviewing the territories' design of their benefits and cost-sharing requirements. Finally, territories were not required to offer freedom of choice of providers.

1. Eligibility Criteria

The territories' Medicaid programs provided territory-wide coverage for children from birth to 18 years of age. They did not offer continuous eligibility, retroactive eligibility, or presumptive eligibility.[2] For those with third-party insurance, Medicaid was the payer of last resort.

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[2] Here, presumptive eligibility refers to a period of time during which a person is considered eligible for Medicaid and services are provided and billed under the assumption that official eligibility determination will occur shortly after receiving services. American Samoa used this

To be eligible, an applicant was required to meet the Medicaid eligibility standards of the territory, as shown in the following table:

	Eligibility Criteria for Medicaid/SCHIP Programs	
Territory	Income	Resources
American Samoa	<40% of FPL	Not reported
CNMI	<133% of FPL	$2,000 per individual $3,000 per couple $150 each additional member
Guam	Comparable to <100% FPL (Basic Standard Need Criteria)	Not reported
USVI	Comparable to <51% of FPL (<$8,500 for family of four plus $1,000 for each additional member)	Family can own domicile. Rental property is part of income. Allowable resources: $1,500 per family, with $100 for each additional member

SOURCE: Mathematica Policy Research analysis of the Territory Evaluation Framework, Section 3.1.1.

Income thresholds ranged from less than 40 percent of poverty (American Samoa) to less than 133 percent of poverty (CNMI). Two territories—CNMI and USVI—reported using a resource test to determine eligibility. The territories required enrollees to report monthly on changes in household or financial circumstances.

American Samoa did not determine eligibility on an individual basis; rather, they used a system that they referred to as "presumed eligibility." Each year, the percentage of the

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(continued)
term to refer to their practice of estimating the percentage of the population eligible for Medicaid.

population falling below the poverty level was estimated.[3] CMS paid expenditures for Medicaid (up to the Federal ceiling) based on that percentage.

2. Delivery System

All four territories relied on a limited set of providers to serve their Medicaid population, and they paid for services on a fee-for-service (FFS) basis.[4] Due to a shortage of providers, the Medicaid programs in the territories were not required to offer enrollees freedom of choice of providers.[5]

- American Samoa's "greatest challenge in providing all covered services" was finding the resources to recruit qualified health care professionals to provide services on the island. Due to poor funding, low salary, geographic isolation from the states, poor housing, and the unavailability of certain specialists, they reported that it was difficult to recruit health care providers.
- CNMI provided almost all Medicaid services through the Commonwealth Health Center on Saipan. Prior approval was required for services delivered outside that center.
- Guam's Department of Public Health and Social Services (DPHSS) operated three clinics that provided services to the entire population on the island, aside from services provided by a few private practitioners.
- All USVI Medicaid clients were required to utilize one of two government clinics and hospitals, or receive prior approval for care outside of these facilities.

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[3] The American Samoa poverty level for family size was computed by multiplying the U.S. family size poverty level by the lower of (1) the ratio of American Samoa median income to the U.S. median income or (2) the ratio of the territory's median income to that of the state receiving the highest FMAP. This computation was then adjusted by a deflator factor. In FY2000, American Samoa estimated 36,549 Medicaid/SCHIP eligibles, based on the 58.6 percent of the population estimated by the US Census Bureau to be below the poverty level.

[4] Puerto Rico delivered most services through a managed care system. Enrollees living in areas without managed care received services through Puerto Rico's public health system (Health Care Financing Administration 1998).

[5] Unlike state Medicaid programs, the territories were not required to apply for waivers to limit freedom of choice of providers.

3. Scope of Benefits and Cost-Sharing Requirements

Due to financial restrictions resulting from the Federal cap on matching funds, the territories provided coverage for fewer services than the Medicaid/M-SCHIP programs in the 50 states and District of Columbia. For example, all Medicaid/M-SCHIP programs in the states and District of Columbia offered inpatient and outpatient mental health care, durable medical equipment, disposable medical supplies, hearing aids, vision screening, physical therapy, speech therapy, occupational therapy, medical transportation, home health services, and case management/care coordination. Not all the territories covered these services (see Table A.1).

- Only American Samoa covered inpatient mental health services. Both American Samoa and USVI provided outpatient mental health services.
- Only Guam covered durable and disposable medical equipment.
- American Samoa and Guam offered physical therapy. USVI was the only territory that covered speech therapy, and Guam was the only territory that offered occupational therapy.

To maximize the number and breadth of services provided to enrollees, the territories reported coordinating with other health programs.

- American Samoa used title V MCH funds to provide well-baby and well-child visits. American Samoa's dental health program sent dental professionals and portable dental equipment to schools to provide restorative services. Immunization staff and mental health social workers accompanied the dental staff and provided immunization and mental health services at the schools.
- CNMI provided developmental assessments, well-baby and well-child visits through its title V MCH program. It funded immunizations through the Vaccines for Children (VFC) program.
- The Guam Department of Public Health and Social Services offered free preventive services through its Dental Division.
- The USVI Medicaid program coordinated service delivery with the title V MCH program.

TABLE A.1

SERVICES COVERED BY TERRITORIES' MEDICAID PROGRAMS

Services	American Samoa	Commonwealth of Northern Mariana Islands (CNMI)	Guam	U.S. Virgin Islands[a] (USVI)
Inpatient hospital services	✓	✓	✓	✓[b]
Emergency hospital services	✓	✓	✓	✓
Outpatient hospital services	✓	✓	✓	✓
Physician services	✓	✓	✓	✓
Clinic services	✓	✓	✓	✓
Prescription drugs	✓	✓	✓	✓[c]
Over-the-counter medications	✓			[d]
Outpatient laboratory and radiology services	✓	✓	✓	✓[e]
Prenatal care	✓	✓	✓	✓
Family planning services	✓	✓	✓	✓
Immunizations	✓	✓[f]	✓	✓
Well-baby visits	✓[g]	✓[h]	✓	✓
Well-child visits	✓	✓[h]	✓	✓
Developmental assessment	✓[i]	✓[h]	✓[j]	✓
Inpatient mental health services	✓			
Outpatient mental health services	✓			✓
Inpatient substance abuse treatment services	✓			✓[k]
Residential substance abuse treatment services				
Outpatient substance abuse treatment services	✓			✓
Durable medical equipment			✓	
Disposable medical supplies			✓	
Preventive dental services	✓	✓	✓[l]	✓
Restorative dental services	✓		✓	✓
Hearing screening		✓	✓	✓
Hearing aids		✓	✓[m]	✓[e]
Vision screening		✓	✓	✓
Corrective lenses (including eyeglasses)	✓[n]	✓	✓	✓[o]
Physical therapy	✓		✓	
Speech therapy				✓
Occupational therapy			✓	
Physical rehabilitation services	✓			
Podiatric services			✓	✓
Chiropractic services				
Medical transportation	✓		✓[p]	✓[q]
Home health services		✓		
Nursing facility		✓		✓[r]

TABLE A.1 *(continued)*

Services	American Samoa	Commonwealth of Northern Mariana Islands (CNMI)	Guam	U.S. Virgin Islands[a] (USVI)
ICF/MR				
Hospice care				
Private duty nursing	✓[r]			
Personal care services				
Habilitative services				
Case management/Care coordination	✓			✓[t]
Non-emergency transportation				✓[q]
Interpreter services				
TOTAL	26	20	25	28

SOURCE: Mathematica Policy Research analysis of the title XXI Territory Evaluations, Section 3.2.1 of the Territory Evaluation Framework.

[a] All USVI Medicaid clients must utilize one of two government clinics and hospitals, or receive prior approval for care outside of these facilities.

[b] The USVI Medicaid program limits inpatient days based on the diagnosis; additional days require pre-approval.

[c] Prescription drugs over $200 must have prior approval from the USVI Medicaid program.

[d] Vitamins for prenatal women in the USVI Medicaid program are the only over-the-counter medication covered by the program; a physician must order the vitamins.

[e] Outpatient lab, radiology, and hearing aids must have prior approval in the USVI Medicaid program.

[f] Due to the Federal Medicaid cap, immunizations in the CNMI are funded through the Vaccines For Children (VFC) program.

[g] Well-child and well-baby visits in American Samoa Medicaid are provided under title V.

[h] Due to the Federal Medicaid cap, developmental assessments, well-baby visits, and well-child visits in the CNMI are funded through the title V-MCH program.

[i] American Samoa limits EPSDT services when Federal funds are exhausted.

[j] Developmental assessments in Guam Medicaid are limited to the EPSDT periodicity schedule for prescribed ages.

[k] The USVI Medicaid program covers inpatient substance abuse treatment services in acute care settings only.

[l] The Dental Division of the Guam Department of Public Health and Social Services offers free preventive services.

[m] The Guam Medicaid program limits hearing aids to one every five years.

[n] American Samoa provides coverage for eyeglasses.

[o] Corrective lenses offered in the USVI Medicaid program follow an established fee schedule.

[p] Medical transportation in Guam Medicaid is limited to off island travel and transportation via ambulance.

[q] The USVI Medicaid program limits transportation benefits to commercial airlines only. For non-emergency transportation, a client must be authorized to travel off the island and there is $520 per year limit.

[r] In American Samoa, these services are provided off-island.

[s] The USVI nursing facilities are limited to a cap of 20 patients.

[t] The USVI Medicaid case management services are in-house only.

The territories reported that they faced financial and geographic barriers to offering certain services, such as specialty care. In all the territories, access to specialty care often required off-island transportation. They noted that off-island services were expensive and had a significant impact on the Medicaid budget. In Guam, for example, 16 to 20 percent of expenditures were for off-island services.

None of the four territories used cost sharing, due, in part, to the relatively low income thresholds of the population served by their programs. In addition, benefit limits were not common, and occurred only in a few situations:

- Hearing aids were limited to one every five years in the Guam Medicaid program.
- Medical transportation in Guam was limited to off-island travel and emergency transportation. In USVI, transportation benefits were limited to commercial airlines only; for non-emergency transportation, a client required authorization to travel off the island, and there was a $520 per year limit.
- In the USVI's Medicaid program, inpatient substance abuse treatment services were covered only in acute-care settings.

C. OUTREACH

SCHIP outreach efforts in the states and District of Columbia were designed to increase awareness of SCHIP by removing language or cultural barriers and providing information about SCHIP to eligible families. Often, the success of these initiatives was measured in terms of the recognition of the program, number of applications, and positive enrollment trends. Some of the territories noted that they were concerned, however, that successful outreach efforts would increase enrollment in their Medicaid programs, and would thereby increase the cost of programs that were already stretched financially. As a result, the territories faced a difficult decision regarding how, and whether, to conduct outreach. Two of the territories reported that they conducted outreach, and two indicated that they did not.

- American Samoa provided information and health education materials at community health centers and schools where services were provided. The program also used media, village meetings, social service agencies, churches, and public eating places to disseminate information. Materials were available in Samoan and there were plans to translate them into Tongan, Fijian, Korean, and Filipino.

- CNMI reported that outreach was not necessary, given the size of the island and the limited locations in which to receive services; all services were offered at the only hospital on the island, the Commonwealth Health Center.

- Guam conducted outreach not only for Medicaid, but also for other programs administered by Guam's DPHSS.[6] DPHSS extended outreach efforts to public schools, Guam Memorial Hospital, government agencies, and malls and other shopping centers. Public health nurses, school nurses, medical social workers, and eligibility workers informed and assisted families in accessing the Federal and local medical assistance programs for uninsured children and families. Families who did not qualify for one assistance program received referrals to other programs.

- USVI did not conduct outreach or patient education for Medicaid or SCHIP. All funds were used to pay for services. The territory did not promote or encourage enrollment, for fear that it would have to assume a larger proportion of costs.

D. CROWD-OUT

The territories indicated that they were not concerned about potential crowd-out in their Medicaid programs for two reasons. First, the territories did not have large private insurance markets, so there were few other options for coverage. Second, the programs in the territories covered Medicaid-eligible children with extremely low income and typically, these children were from families who did not have access to employer-sponsored insurance. For example:

- American Samoa and CNMI said that they both had very small private insurance markets. In American Samoa, only 0.3 percent of the population had private insurance coverage. CNMI had only three private clinics; all other facilities were government owned and operated. Neither territory believed that crowd-out was a concern. For the few people with private insurance, Medicaid was the payer of last resort and coordination of benefits occurred.

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[6] Guam's DPHSS included: the Maternal and Child Health-Family Planning Program (MCH-FP), the Public Health Dental Program, the Communicable Disease Center (CDC), the Women Infant and Children (WIC), Medically Indigent Program, and Medical Social Services.

- Guam did not view crowd-out as an issue, since most of the families in the program were unemployed or worked fewer than 100 hours per month and could not afford private health coverage. To avoid any possible crowd-out, Guam imposed penalties, including disqualification, for applicants who purposely disenrolled from private health insurance coverage in an effort to qualify for government health insurance coverage.

- USVI reported that there was no evidence of crowd-out.

E. ENROLLMENT

The SCHIP Enrollment Data System (SEDS), maintained by CMS, tracks Medicaid and SCHIP enrollment on a quarterly basis. However, given that American Samoa, CNMI, Guam, and USVI used their SCHIP funds to cover costs that exceeded the cap on Federal funding for their Medicaid programs, they were not able to quantify SCHIP enrollment, since all children were classified as Medicaid-eligible.[7] As shown in the table below, Puerto Rico covered by far the largest number of children, followed by American Samoa and USVI. Guam and CNMI each enrolled fewer than 10,000 children in Medicaid.

	Number Ever Enrolled FFY 1999	
Territory	M-SCHIP	Medicaid
Total	20,000	622,536
American Samoa	-	36,549
Guam	-	8,747
CNMI	-	6,045
Puerto Rico	20,000	559,896
USVI	-	11,299

SOURCE: Mathematica Policy Research analysis of CMS's SCHIP Statistical Enrollment Data System (SEDS) as of May 18, 2001, with one exception. The FFY 1999 data for USVI were taken from Section 1.1.1 of the Territory Evaluation Framework.

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[7] Puerto Rico was the only territory able to report the number of children enrolled in M-SCHIP and Medicaid since it was using SCHIP funds for an M-SCHIP program rather than paying for services provided to children in the existing Medicaid program. The SCHIP implementing regulations exempt territories from SEDS reporting.

F. TERRITORY RECOMMENDATIONS FOR IMPROVING THE SCHIP PROGRAM

The territories reported that they were unable to use SCHIP funding to expand coverage to new populations. Rather, the territories had to use the SCHIP funds to cover financial shortfalls in their Medicaid programs. The territories' recommendations for improving the SCHIP program primarily focussed on revising the Federal formulas for distributing Federal funding to the territories for both the Medicaid and SCHIP programs.

In their SCHIP evaluations, the territories recommended the following three actions that could be taken by Congress to achieve parity with the formulas used to fund Medicaid and SCHIP in the 50 states and the District of Columbia:

- Eliminate the Federal fiscal ceiling for territories and allow open-ended Medicaid funding
- Increase the territories' share of the FMAP by utilizing the existing formula for states and eliminate the designation of 50 percent FMAP for the territories
- Increase SCHIP appropriations to territories to bring them in line with the formula used to allocate SCHIP funds to the states

Congress enacted legislation to respond to some of the funding concerns in the territories. The 1999 Omnibus Appropriations Act provided an additional $32 million in FFY 1999 territory appropriations for SCHIP. The 1999 Balanced Budget Act authorized additional SCHIP funding each year for the territories through FY 2007 ($34.4 million for 2000 and 2001, $25.2 million for 2002 to 2004, $32.4 million for 2005 to 2006, and $40 million for 2007) (U.S. House of Representatives 2000).

The territories indicated in their evaluations that they continued to face funding shortages that affected their ability to use title XXI funding to expand eligibility beyond current Medicaid levels as opposed to using the funding solely to cover Medicaid shortfalls. The territories asserted that they would not be able to improve the availability of health insurance and health care for children without further amendments to the Medicaid and SCHIP funding formulas.

APPENDIX B

SUMMARY OF AMENDMENTS TO TITLE XXI STATE PLANS, AS OF MARCH 7, 2001

APPENDIX B

SUMMARY OF AMENDMENTS TO TITLE XXI STATE PLANS, AS OF MARCH 7, 2001

State		Approval Date	Effective Date	Description
Alabama	1	8/18/98	9/1/98	Established the S-SCHIP program
	2	9/24/99	10/1/00	Established All Kids Plus, a wraparound for children with special health care needs
Alaska				No amendment
Arizona	1	5/21/99	1/1/99	Added four reasons why a child would not be guaranteed an initial 12 months of continuous coverage: 1) failure to cooperate; 2) whereabouts of the child are unknown; 3) child is a patient in an institution for mental diseases; and 4) child voluntarily withdraws from the program
	2	8/23/99	10/1/99	Established monthly premiums and increased the income limit to 200 percent of poverty
	3	12/1/99	11/1/98	Amended the reporting requirements regarding quality indicators, strategic objectives and performance goals to the assurances and reports required by title XXI; clarified that cost sharing of any kind will not be imposed on American Indians and that children who have been terminated from private insurance as a result of reaching the lifetime limit are considered uninsured for title XXI eligibility purposes
	4	1/26/01	10/1/00	Amended to accept parental declaration of income for KidsCare program
Arkansas	1	2/16/01	1/1/01	Established S-SCHIP as component of ARKidsB (ARKidsB is a Medicaid section 1115 demonstration); extended coverage to children through age 18 with family income between 150 and 200 percent of poverty
California	1	6/29/98	7/1/98	Established a gross income test for the S-SCHIP program
	2	12/21/99		Increased enrollment broker fees from $25 to $50 per successful applicant
	3	11/23/99		Raised the income threshold from 200 to 250 percent of poverty for S-SCHIP; expanded retroactive coverage for medical services from 30 to 90 days prior to enrollment in Healthy Families; allowed Healthy Families to use the Medi-Cal income disregards
	4	3/6/00		Allowed a Family Contribution Sponsor to pay a specific child's Healthy Families Program premiums for the first year of enrollment
	5	7/7/00		Exempted cost sharing for American Indians and Alaska Native children who meet the eligibility criteria for the Healthy Families Program and provide acceptable documentation of their status
Colorado	1	9/21/99	4/22/98	Expanded the upper age limit from 17 to 18
	2	Pending		
	3	Pending		
Connecticut	1	7/14/00	7/14/00	Provided for the implementation of full mental health parity; provided Husky Part B coverage to children of municipal employees if dependent coverage was terminated due to extreme economic hardship; removed children of Federal employees from the list of ineligible children for Husky, Part B; exempted American Indian/Alaska Native children from cost sharing
Delaware	1	11/23/99	7/1/99	Discontinued the six-month waiting period for people who were disenrolled from the program because they failed to pay their premiums

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Appendix B *(continued)*

State		Approval Date	Effective Date	Description
District of Columbia				No amendment
Florida	1	9/8/98	7/1/98	Expanded eligibility for Healthy Kids from 185 to 200 percent of poverty and added MediKids and CMS
	2	Denied		
	3	3/31/00	10/1/99	Implemented a pilot for minimal dental benefits in two counties
	4	11/8/00	7/1/00	Expanded Medicaid coverage to children under age 1 with family income between 185 and 200 percent of poverty and eliminated coverage for this group under MediKids and title XXI CMS network; implemented mandatory assignment in MediKids for children whose families do not chose a managed care provider within 10 days of receiving a choice-counseling letter
Georgia	1	4/20/00	10/1/99	Modified the reinstatement process to facilitate resuming coverage to children who were cancelled due to non-payment of premiums; exempted cost sharing for American Indian and Alaska Native children who meet the eligibility criteria for the program and provide acceptable documentation of their status
	2	Pending		
Hawaii	1	9/22/00	7/1/00	Expanded eligibility from 185 to 200 percent of poverty and expanded the age criterion from children age 1 through 5 to all children under age 19
Idaho	1	12/4/98	7/1/98	Lowered income threshold from 160 to 150 percent of poverty
	2	Pending		
Illinois	1	3/30/00	8/12/98	Established the S-SCHIP program and introduced cost sharing
Indiana	1	12/22/99	1/1/00	Established the S-SCHIP program
Iowa	1	6/16/99	1/1/99	Established the S-SCHIP program
	2	3/31/00	10/1/99	Established a 20 percent earnings disregard and added Unity Choice from Wellmark Health Plan of Iowa
	3	6/14/00	3/1/00	Added John Deere Health Plan in selected counties; removed cost sharing for American Indian/Alaska Native children; allowed a deduction of capital assets when considering self-employment income
	4	12/18/00	7/1/00	Expanded coverage under the Medicaid program for infants up to 1-year-of-age in families with income at or below 200 percent of poverty; expanded coverage under the HAWK-I program to children up to age 19 in families with income at or below 200 percent of poverty
Kansas	1	4/20/00		Extended coverage to newborns of mothers enrolled for a family member enrolled in S-SCHIP through the end of the current continuous 12-month eligibility period of the family member
Kentucky	1	9/3/99		Expanded M-SCHIP eligibility from 100 percent of poverty for 14 through 18 year old children to 150 percent of poverty for children ages 1 to 19
Kentucky	2	Pending		
Louisiana	1	8/27/99	10/1/99	Expanded eligibility from 133 to 150 percent of poverty
	2	Pending		

Appendix B *(continued)*

State		Approval Date	Effective Date	Description
Maine	1	Pending		
Maryland	1	10/26/00	7/1/98	Under Phase I, provided SCHIP coverage to targeted low-income children ages 1 through 5 in families with income between 133 and 185 percent of poverty; expanded eligibility to children ages 6 and above who were born after September 30, 1983 in families with income between 100 and 185 percent of poverty (prior to 7/1/98, these children were eligible for a section 1115 demonstration project that did not provide inpatient hospital coverage)
	2	11/7/00	7/1/01	Implemented Phase II S-SCHIP program, which provided coverage to children with family incomes between 200 and 300 percent of poverty; for Phase II enrollees, introduced cost-sharing and premium assistance program to provide coverage through employer sponsored health benefits plans that meet title XXI requirements
Massachusetts				No amendment
Michigan	1	6/29/98	5/1/98	Established M-SCHIP program for children 16 through 18 through 150 percent of poverty; reduced family premiums for S-SCHIP to $5 per month regardless of the number of children; eliminated all copayments for S-SCHIP covered services and required final eligibility determinations to be made by State staff
	2	11/7/00	6/1/00	Modified redetermination process; established self-declaration of income
Minnesota				No amendment
Mississippi	1	2/10/99	1/1/00	Established the S-SCHIP program with an income threshold of 133 percent of poverty
	2	12/17/99	1/1/00	Expanded S-SCHIP eligibility from 133 to 200 percent of poverty and introduced cost-sharing elements
	3	10/2/00	10/1/00	Eliminated S-SCHIP 6-month period of uninsurance for children with previous creditable health coverage (however, waiting period will continue to apply to premium assistance program)
Missouri	1	9/11/98		Amended crowd-out policy
Montana	1	10/6/00	6/1/00	Adopted universal application form; modified definition of countable income; eliminated the annual enrollment fee; added a $350 dental benefit and an eyeglasses benefit; increased the annual maximum copayment from $200 to $215; eliminated cost sharing for the American Indian children enrolled in SCHIP
Nebraska	1	10/13/98	9/1/98	Expanded M-SCHIP eligibility from 100 percent of poverty for children ages 15 through 18 to 185 percent of poverty for children under 19 years of age
Nevada	1	9/22/00	5/4/00	Waived cost sharing for American Indians or Alaska Natives or members of Federally recognized Tribes; removed 6-month residency requirement; modified redetermination process so that child is eligible for the program for 1 year from the date of enrollment, provided they continue to meet eligibility criteria
New Hampshire	1	3/25/99	1/1/99	Modified the benefit package

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Appendix B *(continued)*

State		Approval Date	Effective Date	Description
New Jersey	1	5/5/99	1/13/99	Shortened the waiting period from 12 to 6 months
	2	8/3/99	7/1/99	Introduced income disregards, effectively expanding eligibility to 350 percent of poverty
	3	7/7/00	7/26/99	Provided that a child whose gross family income does not exceed 200 percent of poverty (Plans B and C) will be exempt from the 6-month waiting period if the child was covered under an individual health benefits plan or COBRA plan prior to application; exceptions were also granted in Plans B, C, and D if the child had not been voluntarily disenrolled from an ESI plan during the 6-month period prior to application, or the child loses insurance as a result of a job change, when the insured does not have access to affordable coverage in the new job
	4	3/16/00	1/1/00	Established presumptive eligibility if a preliminary determination by staff of an acute care hospital, FQHC, or local health department indicates that the child meets either NJ KidCare Plan A, B, C or Medicaid program eligibility standards, and the child is a member of a household with a gross income not exceeding 200 percent of poverty
New Mexico	1	Denied		
	2	10/30/00	7/1/00	Exempted American Indian children from cost sharing requirements
New York	1	Denied		Requested retroactive matching funds
	2	9/24/99	1/1/99	Expanded M-SCHIP eligibility to children 15 to 18 years in families with incomes at or below 100 percent of poverty (who were not Medicaid eligible prior to March 31, 1997); expanded S-SCHIP eligibility from 185 to 192 percent of poverty; reduced cost-sharing requirements and provided additional benefits to enrollees
North Carolina	1	1/15/99	9/30/98	Modified the definition of "uninsured" to allow children formerly covered under the Caring Program for Children, who are eligible for title XXI, to enroll in SCHIP without a six month waiting period
	2	6/23/99	3/12/99	Expanded the acceptable sites for delivery of clinic services to include School-Based Health Centers
	3	9/30/99	7/1/99	Expanded dental services to include flouride applications, sealants, simple extractions, therapeutic pulpotomies, and prefabricated stainless steel crowns
	4	10/19/00	5/1/00	Eliminated cost sharing for documented American Indian children; effective 10/1/00, exempted children from 2-month waiting period of uninsurance required for eligibility if health insurance benefits have been terminated due to a long-term disability or substantial reduction or limitation in lifetime medical benefits of benefit category
	5	2/16/01	1/1/01	Established a freeze on new program enrollment effective 1/1/01
North Dakota	1	11/12/99	10/1/98	Established the S-SCHIP program
Ohio	1	7/7/00	7/1/00	Increased the income level for eligibility up to 200 percent of poverty
Oklahoma	1	3/25/99	11/1/98	Accelerated the enrollment of children born prior to October 1, 1983
Oregon	1	Pending		
	2	9/11/00	1/1/00	Revised performance measures
	3	Pending		

Appendix B *(continued)*

State		Approval Date	Effective Date	Description
Pennsylvania	1	10/29/98	6/17/98	Expanded eligibility from 185 to 200 percent of poverty
	2	3/7/00	9/1/99	Established disregards for child care and work expenses
	3	3/7/00	9/1/99	Added outpatient mental health services, inpatient and outpatient substance abuse services, rehabilitation services, and disposable medical supplies
	4	12/18/00	9/1/00	Expanded benefits package to include prenatal care and pre-pregnancy family services and supplies
Rhode Island	1	1/5/99	To be determined	Expanded eligibility from 250 to 300 percent of poverty
South Carolina				No amendment
South Dakota	1	10/28/99	4/1/99	Expanded eligibility from 133 to 140 percent of poverty
	2	11/30/00	7/1/00	Eliminated cost sharing for 18 year olds in M-SCHIP.
	3	12/27/00	7/1/00	Established S-SCHIP program to cover children from birth to age 19 in families with income between 140 and 200 percent of poverty
Tennessee	1	Pending		
Texas	1	11/5/99	5/1/00	Established the S-SCHIP program
Utah	1	Denied		
Vermont	1	8/11/99	10/1/99	Increased monthly premiums
	2	2/28/00	12/1/99	Implemented a primary care case management delivery system
	3	1/19/01	2/1/01	Increased premiums in program; exempted American Indian/Alaska Native children from cost sharing
Virginia	1	12/22/00	12/22/00	Changed name of program to Family Access to Medical Insurance Security Plans (FAMIS); expanded coverage to children from birth through 18 with family gross incomes up to 200 percent of poverty; changed benefit package from benchmark-equivalent coverage to coverage which is the same as the benefits offered under the State employees' plan with the addition of physical, occupational, and speech therapy, speech language pathology, and skilled nursing services for special needs children; established premium assistance program for children in families that meet FAMIS eligibility requirements and who have access to health insurance coverage through parent's employer
Washington	1	Pending		
West Virginia	1	3/19/99	1/1/99	Established the S-SCHIP program
	2	9/27/00	10/1/00	Incorporated children from their M-SCHIP into the S-SCHIP, effectively eliminating the M-SCHIP program
	3	10/13/00	11/1/00	Expanded eligibility in separate child health program to children under 19 with income between 150 and 200 percent of poverty; imposed cost sharing on this population
Wisconsin	1	1/22/99	7/1/99	Expanded M-SCHIP eligibility to 185 percent of poverty; parents of children enrolled under this M-SCHIP expansion will be covered at the regular Federal Medical Assistance Percentage (FMAP) using Section 1115 demonstration authority for title XIX; enhanced title XXI FMAP can be used to cover both parents and children if cost-effectiveness for family coverage can be demonstrated; once a family is enrolled, eligibility is retained until family income is above 200 percent of poverty; children living with a caretaker relative will also be covered if not otherwise covered by Medicaid (however, the caretaker relative for these children is not eligible for coverage under this expansion)
Wyoming				No amendment

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Appendix B *(continued)*

SOURCE: CMS Web site as of March 7, 2001.

NOTE: A number of states have amendments to disregard wages paid by the Census Bureau for temporary employment related to Census 2000 activities. Since these are temporary amendments, they are not listed above.

APPENDIX C

SUPPLEMENTAL INFORMATION ON BENEFIT DESIGN AND COST-SHARING STRUCTURE OF SCHIP PROGRAMS

Chapter IV demonstrates that states offer a large number of services to SCHIP enrollees. A simple description of covered services, however, can be misleading because states often impose limits and copayments to control the cost and utilization of services and to reduce inappropriate use. There is considerable variability across states in the benefit limits and cost-sharing provisions, as well as extensive variation by type of service.

This appendix supplements information presented in Chapter IV on the benefit design and cost-sharing features of SCHIP programs. The appendix presents additional details on the scope and range of coverage offered for the following services: physicians' services, preventive care (including developmental assessments), mental health services, substance abuse services, prescription drugs, dental care, and therapeutic services (physical, speech, and occupational). This appendix also presents the results of simulations of the level of out-of-pocket expenditures under SCHIP, taking into account each state's benefit limits and cost-sharing features.

A. STATE VARIATION IN COVERAGE OF PHYSICIANS' SERVICES

All states covered physicians' services in the emergency room, office, and outpatient hospital settings, and all but two states—Pennsylvania and Utah—covered clinic services. Most states did not place strict benefit limits on these services, except Idaho, which limited emergency room (ER) visits to six per year. Table C.1 provides detailed information on benefit limits and cost sharing for physician visits, by location of service.

Many states imposed copayments on physician services, most frequently physician office visits (19 states), followed by visits to the emergency room (16 states), clinics (14 states), and outpatient hospital departments (12 states). Copayments for these services varied by income, plan, and age.

- In Alaska and the Alabama M-SCHIP program, copayments on outpatient hospital and physician services were for 18-year-olds only.
- In Florida, only the Healthy Kids program had copayments. MediKids, CMS, and Medicaid had no copayments.
- Eleven states—Alabama S-SCHIP, Colorado, Illinois, Iowa, Mississippi, Missouri, Montana, New Jersey, New Mexico, North Carolina, and Utah—had copayments that varied by income level.

Copayment amounts also varied by type of service. In a physician's office or clinic, the typical copayment was $5; however, it started as low as $1 and went as high as $10, depending on age and income. Copayments for outpatient hospital visits generally were the same as those for physician visits, except in four states that charged more for hospital-based ambulatory care.

- Alaska charged 18-year-olds for 5 percent of the outpatient hospital visit. Utah charged 10 percent of the visit for its enrollees between 150 and 200 percent of poverty.
- New Mexico charged $15 per outpatient hospital visit versus $5 for physician and clinic visits. Montana charged $5 for outpatient hospital visits versus $3 for physician and clinic visits.

ER visits tended to have higher copayments than visits in other locations. This reflects the fact that ER visits tend to be expensive and they may be used inappropriately for nonurgent care. By setting the ER copayment higher than the copayment in other settings, states hope to encourage families to use the ER only for emergencies, not for primary care. Typically, states waive the copayment if a child is admitted to the hospital or the visit is truly an emergency. Eleven of the 16 states with ER copayments charged more for visits to the ER than for visits to other locations (Arizona, Colorado, Connecticut, Florida (Healthy Kids), Iowa, Mississippi, Montana, New Hampshire, New Jersey, North Carolina, and Washington; see Table C.1). Two of these states—Arizona and Iowa—imposed a copayment only for nonemergency use of the ER and did not charge copayments for physician visits in other locations.

B. COVERAGE OF PREVENTIVE CARE

All states covered immunizations, well-child care, and well-baby care with no cost sharing, as mandated in the title XXI legislation.[1] A few states, however, placed restrictions on coverage of preventive care. For example, Alabama's S-SCHIP program limited well-child visits to one per year. Kentucky limited these visits according to age and health history. Seven states specified that preventive care must follow recognized schedules, such as those developed by the American Academy of Pediatrics (AAP) (Alabama, Arkansas, Connecticut, Florida, Georgia, New York, and North Carolina).

Coverage of developmental assessments is not mandated for S-SCHIP programs and nine states with S-SCHIP programs reportedly did not offer such assessments (Florida Healthy Kids, Georgia, Illinois, Louisiana, Montana, New Jersey, North Carolina, Utah, and West Virginia). In addition, a small number of S-SCHIP states imposed cost sharing or benefit limits on developmental assessments (Colorado, Idaho, Maine, Massachusetts' premium assistance plan, and Missouri).

- Colorado and Missouri imposed income-based copayments for developmental assessments, ranging from $2 to $10 per visit.
- In the MassHealth Premium Assistance plan, developmental assessments were covered under a wraparound benefit package. These services were available to enrollees from birth until three months after their third birthday (or until the first of September for an enrollee whose third birthday is after the first of April), with a $3,200 annual limit and a lifetime maximum allowance of $9,600.[2]

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[1] New Mexico reported cost sharing for certain immunizations.

[2] Early intervention services include screening and need assessment, physical, speech, and occupational therapy, psychological counseling, and nursing care.

- Maine had a limit of two developmental and behavioral evaluations per year. Developmental assessments must be done through the state's Developmental and Behavioral Evaluation clinics.
- Idaho allowed for 12 hours per year of developmental assessments.

Because preventive care is such an important component of care for children, some states have developed mechanisms to ensure that children receive the necessary services. Families enrolled in Alabama's S-SCHIP program, ALL Kids, receive a postcard highlighting the importance of preventive visits and encouraging the family to schedule the appropriate appointments. If a child has not had the necessary visits within the first 120 days of enrollment, the child's name is forwarded to Intracorp, a medical management company that contacts parents whose children have not received both a routine checkup and a preventive dental visit.

C. COVERAGE OF DENTAL SERVICES

The vast majority of states covered preventive and/or restorative dental services under their SCHIP programs (Table C.2). States reported that dental services are highly valued by SCHIP enrollees and often are a major factor in the decision to join SCHIP. California noted, for example, "dental coverage is a magnet to enrollment." All M-SCHIP programs, except New Hampshire's program for infants, offered dental services. Only three S-SCHIP programs—Colorado, Delaware, and Montana—did not cover preventive or restorative dental services.[3] Massachusetts' M-SCHIP program did not cover restorative dental services; but the state's three S-SCHIP programs did offer the benefit.

Benefit limits for dental services were similar to those seen in commercial plans. Thirteen states with S-SCHIP programs limited preventive dental services based on allowable procedures and/or an annual monetary allowance (Alabama, Arkansas, Arizona, Florida, Georgia, Iowa, Kentucky, Michigan, New Hampshire, North Carolina, Oregon, Utah, and Virginia). Three of these states (Florida, Iowa, and Kentucky) also imposed limits on their M-SCHIP programs, as did Ohio's M-SCHIP program. For example:

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[3] Montana's SCHIP program added a dental benefit in FFY 2000.

- Georgia allowed two visits per year for dental exams and screenings and two emergency exams per year.
- Iowa's plans limited preventive care to $1,000 or $1,500 per year.
- Michigan limited visits to two per year and capped spending at $600 per year.

Restorative dental services were subject to procedure and monetary limits in 17 S-SCHIP programs (Alabama, Connecticut, Florida, Georgia, Iowa, Kansas, Maine, Michigan, Mississippi, Nevada, New Hampshire, North Carolina, Oregon, Pennsylvania, Utah, Virginia, and West Virginia) and 5 M-SCHIP programs (Arkansas, Florida, Iowa, Maine, and West Virginia).

- Maine, Nevada, and West Virginia required prior authorization for orthodontics. Kansas did not cover this service at all.
- Connecticut had a $50 allowance per procedure per continuous eligibility period, $250 total allowance per continuous eligibility period for bridges, crowns, root canal, full or partial dentures, or extractions, and a $725 annual allowance for orthodontia.
- New Hampshire's S-SCHIP program covered fillings only up to $500 per year.
- North Carolina limited coverage to simple tooth pulling and removal of part of the nerve (pulpotomy and stainless steel crowns).

Copayments for dental benefits were infrequent. New Mexico was the only state to charge copayments for preventive dental services. Six states (Alabama, California, Illinois, New Jersey Plan C, New Mexico, and Utah) charged copayments for restorative dental benefits. Copayments ranged from $2 to $5 per visit; Utah charged coinsurance at the rate of 20 percent.

D. COVERAGE OF PRESCRIPTION DRUGS

All states offered SCHIP plans with prescription drug benefits, although cost sharing, formularies, and generic substitution policies were common cost-control strategies (Table C.3). This is not surprising, given that prescription drugs are the fastest-growing component of health care expenditures (Heffler et al. 2001). Thirteen S-SCHIP and six M-SCHIP programs imposed copayments on prescription drugs. Copayments ranged from $0.50 for 18-year-olds in Alabama M-SCHIP to $10 in New Jersey's Plan D. States implemented other cost-control strategies as well:

- Eight states encouraged the use of generic drugs in their SCHIP programs by charging higher copayments for brand names (Alabama, Connecticut, Colorado, Illinois' Kid Care Premium, Montana, New Hampshire, New Jersey Plans C and D, and Washington).
- Three S-SCHIP programs—Kentucky, Oregon, and Virginia—and three M-SCHIP programs—Kentucky, Ohio, and Rhode Island—covered drugs found only on the formulary. Utah charged more for drugs not on the formulary.
- Iowa's two health plans had an aggressive approach to controlling prescription drug costs.[4] One had a preferred drug list and a 30-day supply limit. The other required that recipients use generic drugs unless the approved alternative to brand name drugs was not available or the prescribing physician had indicated "no generic substitution." If an enrollee otherwise requested and obtained a brand name drug, the recipient was responsible for the difference of cost between the brand name and generic drugs.
- West Virginia made mandatory substitutions for generics when available.

E. COVERAGE OF MENTAL HEALTH SERVICES

Although all SCHIP programs offered mental health benefits, many states imposed benefit limits and copayments on mental health services in an effort to control costs and utilization. Typically, M-SCHIP and S-SCHIP benefit limits included visit and day limits, annual dollar limits, and diagnostic limits similar to limits used in commercial insurance plans (Table C.4). Twenty of the 34 states with S-SCHIP programs had inpatient and/or outpatient mental health benefit limits (Alabama, Arizona, California, Colorado, Connecticut, Delaware, Georgia, Iowa, Massachusetts Premium Assistance Plan, Montana, New Hampshire, New Jersey Plan D, New York, North Carolina, Oregon, Pennsylvania, Utah, Virginia, Washington, and West Virginia). Only five M-SCHIP programs had limits on outpatient mental health services (Idaho, Mississippi, South Dakota, Texas, and West Virginia).[5]

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[4] The Iowa S-SCHIP program offered services under the Wellmark Plans (Wellmark Classic Blue (Indemnity) and Wellmark Unity Choice (HMO)) and the Iowa Health Solutions Health Plan (HMO).

Nearly half of the S-SCHIP programs used day and visit limits to control mental health utilization (Alabama, Arizona, California, Colorado, Delaware, Georgia, Iowa, Massachusetts, Montana, New Hampshire, New Jersey, New York, Pennsylvanian, Utah, and West Virginia). Combined mental health and substance abuse service limits were reported in four states (Arizona, Iowa, Montana, and New York). In Arizona, for example, there was a 30-day annual limit for inpatient care for mental health and substance abuse. Montana had a 21-day inpatient limit but allowed one inpatient day to be exchanged for two partial hospitalization days.

State mental health parity laws have affected benefit limits by excluding certain conditions from limits.

- Montana imposed day and visit limits on mental health treatment unless the child had a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, or autism.
- Colorado had day and visit limits for those conditions that were not neurobiologically based.

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[5] In addition, Minnesota's Medicaid program imposed benefit limits on mental health services; however, the SCHIP program only covered children from birth through age two between 275 and 280 percent of poverty.

- Following the implementation of Connecticut's parity law, benefit limits applied only to treatment for mental retardation, learning, motor skills, communication and caffeine-related disorders, and relation problems.

S-SCHIP programs in five states required copayments for inpatient mental health services (Alabama, Illinois, Montana, New Hampshire, and Utah), as did the M-SCHIP program in New Mexico. Copayments for outpatient mental health visits were more common. Nine S-SCHIP programs and one M-SCHIP program used this method to control utilization (California, Colorado, Connecticut, Florida (Healthy Kids), Illinois, New Hampshire, Montana, New Jersey (Plans C and D), New Mexico, and Utah). In general, the copayment amounts for mental health services were nominal (less than $5 per inpatient stay or per visit in most states). Connecticut was the only state to use a graduated schedule based on the number of visits: the first 10 visits had no cost sharing; visits 11 to 20 required a $25 copayment; and visits 21 to 30 were charged the lesser of $50 or 50 percent.

F. COVERAGE OF SUBSTANCE ABUSE SERVICES

Inpatient and outpatient substance abuse treatment was available in most (but not all) SCHIP programs (Table C.5). However, coverage varied by type of service. Among M-SCHIP programs, two states reportedly did not cover inpatient substance abuse treatment services (Texas and Idaho), while Arkansas did not cover outpatient treatment. All S-SCHIP programs offered outpatient substance abuse treatment, while all but one covered inpatient treatment (Wyoming). Three S-SCHIP programs appeared to limit their inpatient substance abuse benefit to acute medical detoxification only (Arizona, Colorado, and New Jersey Plan D). Residential substance abuse treatment was less likely to be covered by both M-SCHIP and S-SCHIP programs. Seven states with M-SCHIP programs did not cover residential substance abuse treatment (Arkansas, Florida, Idaho, Louisiana, New Hampshire, New Jersey, and Texas), while nine states with S-SCHIP programs did not cover this service (California, Colorado, Connecticut, Florida MediKids, Iowa, Massachusetts' three S-SCHIP plans, New Hampshire, New Jersey, and Wyoming).

For those states that offered substance abuse coverage, benefit limits—primarily day and visit limits—were quite common and occurred far more frequently in S-SCHIP than in M-SCHIP programs. South Dakota had the only M-SCHIP program with day and visit limits, covering 45 days of inpatient treatment and 60 hours of outpatient treatment per year. Twelve states had S-SCHIP programs with day limits on inpatient substance abuse treatment (Alabama, Arizona, Connecticut, Delaware, Georgia, Iowa, Massachusetts' premium assistance plan, New Hampshire, New York, Pennsylvania, Utah, and West Virginia); seven of these states also had day limits on residential substance abuse treatment (Alabama, Arizona, Delaware, Georgia, New York, Pennsylvania, and Utah). Outpatient substance abuse treatment visit limits occurred in 16 S-SCHIP programs (Alabama, Arizona, California, Colorado, Connecticut, Delaware, Iowa, Maine, Massachusetts' premium assistance plan, New Hampshire, New York, North Carolina, Pennsylvania, Utah, Virginia, and West Virginia). Most day limits ranged from 20 to 30 days per year in inpatient and residential settings and 20 to 30 visits annually for outpatient services. Three states indicated, however, that limits may be extended if medically necessary and approved by a case manager (North Carolina, Virginia, and West Virginia).

Monetary limits, such as annual or lifetime limits, were reported by a few states, such as Mississippi. Its M-SCHIP program covered $8,000 per benefit period and $16,000 per lifetime for residential and outpatient substance abuse. Inpatient care had no limits. Often, monetary limits were combined with day and visit limits. For example:

- Massachusetts' Family Assistance Premium program limited outpatient substance abuse treatment to 20 visits per year or $500 annually.

- The Iowa Health Solutions plan had a $9,000 annual limit and $39,000 lifetime limit for inpatient and outpatient services combined.

States also controlled services by limiting the acceptable locations and providers, limiting the conditions covered, and limiting eligibility for those services.

- Arizona, Colorado, and New Jersey's Plan D limited inpatient substance abuse care to detoxification only.
- Arkansas, Georgia, and New Jersey M-SCHIP covered only inpatient substance abuse services in acute care facilities. Georgia required that outpatient treatment be provided in a community mental health center.
- Ohio and Oregon required that outpatient treatment providers be certified by the state substance abuse agencies, while inpatient treatment could only be provided in a residential or other community setting (Ohio) or a structured 24-hour supervised treatment facility (Oregon).
- Virginia covered inpatient and residential substance abuse treatment for pregnant women only.

Copayments were another tool used by states to control the utilization and cost of substance abuse services. For inpatient and residential substance abuse services, four S-SCHIP programs charged copayments, ranging from $2 to $25 per admission (Alabama, Illinois, Montana, and Utah). New Mexico's M-SCHIP program required a $25 copayment for inpatient and residential stays; Missouri imposed copayments on the intake and assessment prior to a residential stay.

Copayments were more common for outpatient substance abuse services. Payments for outpatient services tended to range from $2 to $5 per visit, although Utah imposed a 50 percent coinsurance charge per visit for its Plan B enrollees. These costs were similar to those for other physician services. Seven states with S-SCHIP programs had copayments (California, Colorado, Florida, Illinois, Montana, New Jersey (Plan D), and Utah). New Mexico was the only state with an M-SCHIP program that required copayments for outpatient substance abuse treatment.

G. COVERAGE OF PHYSICAL, SPEECH, AND OCCUPATIONAL THERAPY

Most states offered physical, speech, and occupational therapy as part of the SCHIP benefit package (Table C.6). All M-SCHIP programs, except New Hampshire's program for infants, offered these therapies. In addition, almost all S-SCHIP programs offer these therapies: Montana did not offer any of the three types of therapies; Wyoming did not offer speech or occupational therapy; and Kentucky did not offer occupational therapy.

Most states chose to place benefit limits on the amount of services covered (such as number of visits or hours), rather than impose copayments. Seventeen states with S-SCHIP programs imposed limits on therapies (California, Connecticut, Florida, Georgia, Iowa, Maine, Massachusetts, New Hampshire, New Jersey, New York, North Carolina, Oregon, Pennsylvania, Utah, Vermont, Washington, and West Virginia). Only six states with M-SCHIP programs imposed benefit limits for therapeutic services (Arkansas, Idaho, Maine, Minnesota, New Jersey, and Ohio).

- Florida's Healthy Kids program allowed for 24 sessions within a 60-day period.
- Maine limited physical and occupational therapy to two hours per day.
- New Hampshire limited physical and occupational therapy to 24 combined visits; speech therapy had a separate 24-visit limit.
- Utah had a limit of 16 visits per year for any combination of physical, occupational, or speech therapy.
- Colorado had a 30-visit limit on any combination of therapy services per diagnosis per benefit period.
- West Virginia used a combination of visit and dollar limits. Physical therapy was limited to 20 visits in a 12-month period; speech and occupational therapy limits were $1,000 each year.

Some states set limits, but with prior approval would allow a recipient to surpass specified limits (Arkansas, Georgia, and Vermont). For example, Arkansas covered four 30-minute units of evaluation per state fiscal year and four 15-minute units per day for therapy. These limits could be extended upon determination of medical necessity. Vermont required prior approval after the first four months of treatment.

A few states with S-SCHIP programs imposed cost sharing in addition to benefit limits (California, Colorado, Florida (Healthy Kids), New Hampshire, New Jersey (Plans C and D), and Utah). Only two M-SCHIP programs charged copayments (Missouri and New Mexico), although Missouri's copayments were for therapeutic evaluations only. Copayments ranged from $2 to $10 and varied with income in a few states (Colorado, Missouri, New Jersey, New Mexico, and Utah).

H. SIMULATION OF OUT-OF-POCKET EXPENDITURES UNDER SCHIP

Given the variability and complexity of SCHIP benefits and cost-sharing provisions across states (and even, within states, across programs), it is difficult to grasp all the nuances and discern how the effective level of coverage varies for families. To address this challenge, we performed simulations of the out-of-pocket expenditures that would be incurred by SCHIP enrollees in the 29 states with cost sharing. These simulations are a tool for summarizing the effects of variations in the scope of coverage offered by SCHIP programs, and they show the effects of cost sharing and benefit limits on families with different health profiles. Our objective is to compare the relative levels of cost sharing across states, and determine the extent to which families may approach or exceed the 5-percent cost-sharing cap.

1. Methodology

In order to simulate what families would spend out-of-pocket on an annual basis for services provided under SCHIP, we used information reported by states in their title XXI state evaluations on the features of their benefit packages and cost-sharing requirements. We created composite utilization profiles for three hypothetical SCHIP families, to capture the differential effects by health status:[6]

- ***Family 1.*** This family consists of two children, ages 7 and 10, without chronic conditions. Our simulation assumes that each child would have two physician office visits, one preventive care visit, one preventive dental visit, one restorative dental visit, two generic prescriptions, and one brand name prescription (30-day supply per prescription).
- ***Family 2.*** This family consists of one 7-year-old child without a chronic condition and one 10-year-old child with a chronic neuromuscular condition. The 7-year-old child would have the same utilization pattern described for a child in Family 1. Our analysis assumes that the child with a chronic neuromuscular condition would have 6 physician office visits, 4 non-emergent emergency room visits, 2 preventive care visits, 1 preventive dental visit, 1 restorative dental visit, 10 physical therapy sessions, 5 occupational therapy sessions, 5 speech therapy sessions, and 1 vision exam. We also assume that the child would have 12 generic prescriptions and 12 brand name prescriptions (30-day supply per prescription). Our analysis also assumes the family would purchase one piece of durable medical equipment and a pair of eyeglasses.
- ***Family 3.*** This family consists of one 7-year-old child without a chronic condition and one 10-year-old child with an acute psychiatric disorder. The 7-year-old child would have the same utilization pattern described above for a child in Family 1. Our analysis assumes that the child with an acute psychiatric disorder would have 4 physician office visits, 1 preventive care visit, 1 non-emergent emergency room visit, 1 preventive dental visit, 1 restorative dental visit, and 20 mental health visits. We also assume the child would have 9 generic prescriptions and 9 brand name prescriptions (30-day supply per prescription).

We first performed the simulation for all three families based on covered benefits, assuming that children would receive only those services that were covered and would not receive services that exceeded the benefit limits or that were not covered.[7] Then we replicated the simulation for all three families, assuming that children would receive services, whether they were covered or not.

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[6] Some of the assumptions used in the hypothetical scenarios were adapted from Fox et al. (1998).

[7] Alabama did not cover DME; Colorado did not cover restorative dental work; Delaware and Florida did not cover dental services; Iowa covered only the first $50 of vision services; Mississippi covered restorative dental work only if it resulted from an accident; Montana did not cover DME, dental services, eyeglasses, and occupational, physical, or speech therapy; New Jersey did not cover DME or dental services at 250 percent FPL; Utah did not cover eyeglasses.

As with all simulations, we relied on a number of assumptions that can affect the results. First, we picked three poverty levels for which to simulate out-of-pocket expenditures: 150, 200, and 250 percent of poverty. Cost sharing may vary as a percent of income depending on a state's cost-sharing structure. Second, our findings could be sensitive to our assumptions about the level of utilization. For example, we assumed that the child in Family 3 would receive 20 mental health visits. Since the benefit package packages vary by state, some states may cover fewer or more visits than the 20 that we selected. Therefore, a family's out-of-pocket cost could be higher in states that cover fewer visits than in states that cover more visits.

2. Findings

Based on the three simulations, we found the level of cost sharing for covered services was well below the 5 percent cap in each state—even in families with one child with special health care needs (that is, Families 2 and 3) (Table C.7). Out-of-pocket expenses rarely amounted to more than 2 percent of family income.

- At 150 percent of poverty cost sharing ranged from 0.0 to 1.06 percent for Family 1, from 0.0 to 1.74 percent for Family 2, and from 0.0 to 1.60 percent for Family 3.
- At 200 percent of poverty, cost sharing ranged from 0.0 to 1.47 percent for Family 1, from 0.0 to 2.73 percent for Family 2, and from 0.0 to 2.91 percent for Family 3.
- At 250 percent of poverty cost sharing ranged from 0.07 percent to 2.06 percent for Family 1, 0.22 percent to 2.91 percent for Family 2, and 0.17 to 2.42 percent for Family 3.

In most states, the level of cost sharing on covered services was well below the 5 percent cap due to the way states designed their cost-sharing policies. Not only were premiums, enrollment fees, and copays minimal for low-income families, but also cost sharing was not required on all services (as required by title XXI). In a few states, however, out-of-pocket expenditures consistently exceeded 2 percent of family income for certain groups (Connecticut, Missouri, New Hampshire, New Jersey, and Utah). These states charged both premiums and copays (except for Utah, which charged copayments or coinsurance only).

In general, the level of cost sharing increased with income, thus explaining why higher income families had greater out-of-pocket costs. In 12 states, however, we saw that, for at least one of the families in our simulation, the proportion of income devoted to cost sharing was higher for low-income families. In most cases, this was the result of states applying a uniform cost-sharing structure on SCHIP enrollees, rather than using a tiered system in which cost sharing increased with a family's income. In Washington, for example, Family 1 at 150 percent of poverty would pay 1.06 percent of income toward cost sharing, compared to 0.76 percent for a family at 200 percent of poverty, or 0.63 percent at 250 percent of poverty.

In the states that used a tiered system of cost sharing, there were significant marginal increases in cost sharing as families moved up the income scale. In New Jersey, for example, families at 251 percent of poverty were subject to significantly higher premiums and cost-sharing requirements than families at 250 percent of poverty. For families at 250 versus 251 percent of poverty, cost sharing would increase from 0.94 to 1.78 percent of income for Family 1; from 1.83 to 2.67 percent for Family 2; and from 2.42 to 3.26 percent for Family 3. Nevertheless, cost sharing as a percent of income remained well below the 5 percent cap, even taking into account the marginal effect of cost sharing when crossing from one income threshold to the next.

In a few states, the level of out-of-pocket spending was understated in the simulation because some services were not covered under S-SCHIP (most commonly dental services and DME). Therefore, we also simulated out-of-pocket expenditures for families in states where certain services were not covered (Table C.8). We made the following assumptions about the costs of services when they were not covered: (1) dental services and vision services would cost $50 per visit; (2) eyeglasses would cost $100; (3) DME, $1,500; and (4) occupational therapy, physical therapy, and speech therapy, $50 per session.

The simulation revealed that, in some cases, cost sharing may exceed 5 percent of family income when noncovered services are taken into account. The major factor in our hypothetical example is the cost of noncovered DME services (which we assumed would amount to $1,500 per year for Family 2). In the three states that reported they did not cover DME—Alabama, Montana, and New Jersey at 250 percent of poverty—out-of-pocket expenditures for Family 2 exceeded 5 percent of family income, accounting for as much as 10.42 percent of income for a family at 150 percent of poverty in Montana.[8] In Alabama, out-of-pocket expenses would amount to 5 or 6 percent of family income, and in New Jersey, they would account for 6 percent of income for families at 250 percent of poverty. These results, however, were driven by our assumptions regarding expenditures for services not covered by SCHIP. To the extent that families would forgo such services, or would spend less than what we assumed, expenditures as a percent of family income would be lower.

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[8] Montana noted in its state evaluation that it has wrestled with the trade-off of offering more generous coverage to few children and less generous coverage to more children. The state expanded benefits in FFY 2000 to include dental services and eyeglasses, and increased mental health benefits for children with severe emotional disturbance.

In summary, states appear to have structured their SCHIP cost-sharing requirements to make it impossible for families to exceed the 5 percent cap for covered services, as mandated in title XXI. However, certain families may incur cost sharing that exceeds 5 percent of family income, when the cost of noncovered services (especially DME) is taken into account. What this simulation cannot predict is the extent to which families will go without coverage or without care due to the financial hardship of premiums or copayments.

I. CONCLUSION

This appendix has demonstrated that there is considerable variation across states in both the benefit design and cost-sharing structure under SCHIP programs. Detailed information on the content of each state's benefit package is key to understanding the depth and breadth of coverage offered under SCHIP. Benefit limits and cost-sharing requirements may serve as a barrier to children receiving necessary care, particularly those with special health care needs.

- Although all states offered preventive care through their SCHIP programs, eight reported that they placed restrictions on the number or periodicity of visits. In addition, eight states with S-SCHIP programs did not cover developmental assessments, and another five states imposed cost-sharing or benefit limits on such services.
- Fourteen states placed limits on the scope or quantity of preventive dental services that were covered, and 18 states placed limits on restorative services. Such limits were far more common among S-SCHIP programs than among M-SCHIP programs.
- Thirteen S-SCHIP and six M-SCHIP programs imposed copayments on prescription drugs. Other cost-control mechanisms included generic substitution policies and formularies.
- All SCHIP programs offered mental health benefits, but they typically limited services based on visit or day limits, annual dollar limits, or diagnostic limits. Twenty of the 34 S-SCHIP programs had inpatient and/or outpatient mental health benefit limits; only 5 M-SCHIP programs had limits on outpatient mental health services.
- Substance abuse treatment was available in most SCHIP programs, although coverage varied by type of service. In particular, residential treatment was not routinely

covered: seven M-SCHIP and nine S-SCHIP programs did not offer residential treatment.

- Most SCHIP programs covered physical, speech, and occupational therapy as part of their SCHIP programs. However, 17 states with S-SCHIP programs and 6 states with M-SCHIP programs imposed benefit limits, most often in terms of the number of visits or hours of service that were covered.

Although simulations suggest that few families will reach the 5 percent cost-sharing cap, further analysis, based on actual claims history is required to ascertain the patterns of utilization among children enrolled in SCHIP. Further research also is required to determine whether certain groups of enrollees experience higher levels of unmet need due to benefit limits or cost-sharing provisions.

TABLE C.1

BENEFIT LIMITS AND COST SHARING FOR EMERGENCY ROOM, OUTPATIENT HOSPITAL, PHYSICIAN, AND CLINIC SERVICES

State	Program Type	Emergency Room Services	Outpatient Hospital	Physician Services	Clinic Services
Alabama	S-SCHIP	100 to 150% FPL - No cost sharing 151 to 200% FPL - $5 copay per visit	100 to 150% FPL - No cost sharing 151 to 200% FPL - $5 copay for accidental injury (AL1)	100 to 150% FPL - No cost sharing 151 to 200% FPL - $5 copay per visit	100 to 150% FPL - No cost sharing 151 to 200% FPL - $5 copay per visit
	M-SCHIP	No cost sharing	For 18-year -olds, $3 copay per visit (AL2)	For 18-year-olds, $1 copay per visit (AL2)	No cost sharing
Alaska	M-SCHIP	No cost sharing	For 18-year-olds, 5% of charges (AK1)	For 18-year-olds, $3 per visit (AK1)	No cost sharing
Arkansas	M-SCHIP	No cost sharing (a)	No cost sharing (a)	No cost sharing (a)	No cost sharing (a)
Arizona	S-SCHIP	$5 for non-emergency use	No cost sharing (AZ1)	No cost sharing (AZ2)	No cost sharing
California	S-SCHIP (CA1)	$5 copay unless admitted (a)	$5 copay (a)	$5 copay for outpatient physician services (a)	$5 copay (a)
	M-SCHIP	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits
Colorado	S-SCHIP	≤150% FPL - $5 copay 151 to 185% FPL - $15 copay	No cost sharing	<101 FPL - $0 copay 101 to 150% FPL - $2 copay 151 to 185% FPL - $5 copay	<101 FPL - $0 copay 101 to 150% FPL - $2 copay 151 to 185% FPL - $5 copay unless primary care visit
Connecticut	S-SCHIP	$25 copay unless admitted	No cost sharing	$5 copay for outpatient physician services	$5 copay
	M-SCHIP	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits
Delaware	S-SCHIP	No cost sharing	No cost sharing	No cost sharing	No cost sharing
District of Columbia	M-SCHIP	No cost sharing	No cost sharing	No cost sharing	No cost sharing
Florida	S-SCHIP (FL1)	Healthy Kids - $10 copay unless admitted MediKids, CMS - No cost sharing (FL2)	No cost sharing	Healthy Kids - $3 copay unless preventive visit MediKids, CMS - No cost sharing (FL3)	Healthy Kids - $3 copay for outpatient services MediKids, CMS - No cost sharing (FL3)
	M-SCHIP	No cost sharing (FL2)	No cost sharing	No cost sharing (FL3)	No cost sharing (FL3)
Georgia	S-SCHIP	No cost sharing	No cost sharing	No cost sharing (c)	No cost sharing
Hawaii	M-SCHIP	No cost sharing	No cost sharing	No cost sharing	No cost sharing
Idaho	M-SCHIP	No cost sharing (ID1)	No cost sharing	No cost sharing	No cost sharing
Illinois	S-SCHIP (IL1)	KidCare Share - $2 per visit KidCare Premium - $5 per visit or $25 per visit (when used for non-ER reason)	KidCare Share - $2 per visit KidCare Premium - $5 per visit	KidCare Share - $2 per visit KidCare Premium - $5 per visit	KidCare Share - $2 per visit KidCare Premium - $5 per visit
	M-SCHIP	No cost sharing	No cost sharing	No cost sharing	No cost sharing

TABLE C.1 *(continued)*

State	Program Type	Emergency Room Services	Outpatient Hospital	Physician Services	Clinic Services
Indiana	S-SCHIP	(c)	(c)	(c)	(c)
	M-SCHIP	No cost sharing	No cost sharing	No cost sharing (IN1)	No cost sharing
Iowa	S-SCHIP (IA1)	Wellmark and Iowa Solutions Plans at 150 to 185% FPL - $25 copay if not emergency (prudent layperson rule) (a)	No cost sharing (a)	No cost sharing (a)	No cost sharing (a) (IA2)
	M-SCHIP	No cost sharing (a)	No cost sharing (a)	No cost sharing (a)	No cost sharing (a)
Kansas	S-SCHIP	No cost sharing (a)	No cost sharing (a)	No cost sharing	No cost sharing (a)
Kentucky	S-SCHIP	No cost sharing (KY1)	No cost sharing (KY1, KY2)	No cost sharing (KY1)	No cost sharing (KY1)
	M-SCHIP	No cost sharing (KY1)	No cost sharing (KY1,KY2)	No cost sharing (KY1)	No cost sharing (KY1)
Louisiana	M-SCHIP	No cost sharing	No cost sharing	No cost sharing	No cost sharing
Maine	S-SCHIP	No cost sharing	No cost sharing (ME1)	No cost sharing	No cost sharing
	M-SCHIP	No cost sharing	No cost sharing (ME1)	No cost sharing	No cost sharing
Maryland	M-SCHIP	No cost sharing	No cost sharing	No cost sharing	No cost sharing
Massachusetts	S-SCHIP (MA1)	No cost sharing	No cost sharing	No cost sharing	No cost sharing
	M-SCHIP	No cost sharing	No cost sharing	No cost sharing	No cost sharing
Michigan	S-SCHIP	No cost sharing (a)	No cost sharing (a)	No cost sharing (a)	No cost sharing (a)
	M-SCHIP	No cost sharing (a)	No cost sharing (a)	No cost sharing (a)	No cost sharing (a)
Minnesota	M-SCHIP	No cost sharing (MN1)	No cost sharing (MN1)	No cost sharing (MN1)	No cost sharing (MN1)
Mississippi	S-SCHIP	150 to 200% FPL - $15 copay (MS1)	No cost sharing	150 to 200% FPL - $5 copay (MS1)	No cost sharing
	M-SCHIP	No cost sharing	No cost sharing	No cost sharing	No cost sharing
Missouri	M-SCHIP	No cost sharing	Copay for therapy evaluations and facility charges 186 to 225% FPL - $5 copay 226 to 300% FPL - $10 copay	186 to 225% FPL - $5 copay 226 to 300% FPL - $10 copay	186 to 225% FPL - $5 copay 226 to 300% FPL - $10 copay
Montana	S-SCHIP	>100% FPL - $5 copay	>100% FPL - $5 copay	>100% FPL - $3 copay	>100% FPL - $3 copay
Nebraska	M-SCHIP	No cost sharing	No cost sharing	No cost sharing	No cost sharing
Nevada	S-SCHIP	No cost sharing	No cost sharing	No cost sharing	No cost sharing
New Hampshire	S-SCHIP	$25 copay unless admitted	No cost sharing	$5 copay for office visits	$5 copay for office visits
	M-SCHIP	No cost sharing	No cost sharing	No cost sharing	No cost sharing
New Jersey	S-SCHIP (NJ1)	Plan B - No cost sharing Plan C - $10 copay per visit Plan D - $35 copay per visit	Plan B - No cost sharing Plan C - $5 copay unless preventive visit Plan D - $5 copay per visit	Plan B - No cost sharing Plan C - $5 copay unless preventive visit Plan D - $5 copay for office visit; $10 copay for home visit or off hours visit; $5 copay for well child care, immunizations, and specialists; copay only applies to first prenatal visit	Plan B - No cost sharing Plan C - $5 copay unless preventive visit Plan D - No copay for preventive services; $5 copay for office visit; $10 copay for home visit or off hours visit; copay only applies to first prenatal visit.
	M-SCHIP	No cost sharing	No cost sharing	No cost sharing	No cost sharing
New Mexico	M-SCHIP	<185% FPL - No copay 185 to 235% FPL - $15 copay (NM1)	<185% FPL - No copay 185 to 235% FPL - $15 copay (NM1)	<185% FPL - No copay 185 to 235% FPL - $5 copay (NM1)	<185% FPL - No copay 185 to 235% FPL - $5 copay (NM1)

TABLE C.1 *(continued)*

State	Program Type	Emergency Room Services	Outpatient Hospital	Physician Services	Clinic Services
New York	S-SCHIP	No cost sharing (a)	No cost sharing	No cost sharing	No cost sharing
	M-SCHIP	No cost sharing	No cost sharing (a)	No cost sharing (a)	No cost sharing (a)
North Carolina	S-SCHIP	>150% FPL - $20 copay	No cost sharing	>150% FPL - $5 copay	No cost sharing
North Dakota	S-SCHIP	(c)	(c)	(c)	(c)
	M-SCHIP	No cost sharing	No cost sharing	No cost sharing	No cost sharing
Ohio	M-SCHIP	No cost sharing	No cost sharing	No cost sharing	No cost sharing
Oklahoma	M-SCHIP	No cost sharing	No cost sharing	No cost sharing	No cost sharing
Oregon	S-SCHIP	No cost sharing (OR1)	No cost sharing (OR1)	No cost sharing (OR2)	No cost sharing (OR3)
Pennsylvania	S-SCHIP	No cost sharing	No cost sharing	No cost sharing	Clinic services not covered
Rhode Island	M-SCHIP	No cost sharing	$5 copay unless prenatal or preventive visit (RI1)	$5 copay unless prenatal or preventive visit (RI1)	$5 copay unless prenatal or preventive visit (RI1)
South Carolina	M-SCHIP	No cost sharing (a)	No cost sharing (a)	No cost sharing (a)	No cost sharing (a)
South Dakota	S-SCHIP	(c)	(c)	(c)	(c)
	M-SCHIP	No cost sharing	No cost sharing	No cost sharing	No cost sharing
Tennessee	M-SCHIP	No cost sharing (a)	No cost sharing (a)	No cost sharing (a)	No cost sharing (a)
Texas	S-SCHIP	(c)	(c)	(c)	(c)
	M-SCHIP	No cost sharing	No cost sharing	No cost sharing	No cost sharing
Utah	S-SCHIP (UT1)	Plan A - $5 copay for emergent use; $10 copay for non-emergent use Plan B - $30 copay	Plan A - No cost sharing Plan B - patient pays 10% of visit	Plan A - $5 copay unless preventive visit Plan B - $10 copay unless preventive visit	Service not covered
Vermont	S-SCHIP	No cost sharing	No cost sharing	No cost sharing	No cost sharing
Virginia	S-SCHIP	No cost sharing	No cost sharing (VA1)	No cost sharing (VA2)	No cost sharing (VA3)
Washington	S-SCHIP	$25 copay (b)	No cost sharing	$5 copay (excluding immunizations, well-child checkups)	$5 copay for visits with physicians, advanced practice nurse practitioners, and physician assistants (excluding immunization and well-child checks)
West Virginia	S-SCHIP	No cost sharing	No cost sharing (WV1)	No cost sharing	No cost sharing
	M-SCHIP	No cost sharing	No cost sharing	No cost sharing	No cost sharing
Wisconsin	M-SCHIP	No cost sharing	No cost sharing (WI1)	No cost sharing (WI1)	No cost sharing (WI1)
Wyoming	S-SCHIP	No cost sharing	No cost sharing	No cost sharing	No cost sharing

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations, Section 3.2.1 of the State Evaluation Framework.

(a) Service must be medically necessary.
(b) Prior approval required.
(c) Program not implemented at time of title XXI State Evaluation.

AL1 In the Alabama S-SCHIP program, certain services performed in preferred outpatient facilities have no cost sharing: surgery, hemodialysis, IV therapy, chemotherapy, radiation, diagnostic laboratory and x-ray.

TABLE C.1 *(continued)*

AL2	In the Alabama M-SCHIP program, treatment cannot be denied for nonpayment of copay by 18-year-olds. There are no benefit limits if the condition is identified during an EPSDT screening.
AK1	Cost sharing for 18-year-olds apply only to 18-year-olds that are not pregnant or Alaska Natives.
AZ1	Coverage is limited to outpatient hospital services ordinarily provided in hospitals, clinics, offices and other health care facilities by licensed health care providers. Outpatient hospital services include service provided by or under the direction of a PCP or primary care practitioner or licensed behavioral health professional according to Federal and state law.
AZ2	Coverage is limited to physician services if provided by or under the direction of a PCP, psychiatrist, or under the direction of a primary care practitioner according to Federal and state law. Services are covered whether furnished in the office, the member's home, a hospital, a nursing home, or other setting.
CA1	Children with special needs receive services through CCS and CMH at no cost.
FL1	Florida has three S-SCHIP programs: Healthy Kids, MediKids, and CMS. Healthy Kids covers children 5 - 19 years between 101 and 200% of poverty. (In some counties younger siblings may be covered in HealthyKids.) MediKids covers children from birth to age five; the income levels vary according to a child's age, but the threshold is 200% of poverty. CMS offers coverage for disabled children from birth to 19; the income levels vary according to a child's age, but the threshold is 200% of poverty.
FL2	Children in Medicaid, MediKids, and CMS using ER services must be triaged by the hospital.
FL3	In Medicaid, MediKids, and CMS, there are no limits to physician services and clinic services provided that the services are within AAP guidelines.
ID1	ER visits limited to 6 per year.
IL1	Illinois has two S-SCHIP programs: KidCare Share and KidCare Premium. KidCare Share covers children between 134 and 150% of poverty; KidCare Premium covers children between 151 and 185% of poverty. The annual copayment maximum is $100 per family. Families with American Indian or Alaska Native children do not pay premiums or copays.
IN1	Prior authorization is required for more than 30 PMP visits in a 12-month period.
IA1	Iowa's S-SCHIP program offers services under the Wellmark Plans (Wellmark Classic Blue (Indemnity) and Wellmark Unity Choice (HMO)) and the Iowa Health Solutions Health Plan (HMO).
IA2	Covered clinic services in the Wellmark plans are outpatient physician clinic services.
KY1	The Medicaid provider network must provide all benefits. Primary care provider referrals are required for some services provided through managed care.
KY2	There are no benefit limits on outpatient hospital services, but the following are excluded: drugs, biologicals and injectibles dispensed to recipients; items and services which are not reasonable and necessary and related to the diagnosis or treatment of illness or injury; occupational therapy; and routine physical examinations.
ME1	No cosmetic, experimental, investigational services are covered under outpatient hospital benefits.
MA1	Massachusetts has three different S-SCHIP programs: Family Assistance Direct Coverage (FADC) is the state's separate S-SCHIP for children 1 to 18 years between 150 and 200% of poverty; Family Assistance Premium Assistance (FAPA) is an employer buy-in program for those with access to employer-sponsored (ESI) insurance between 150 and 200% of poverty; and CommonHealth (CH) is a program for disabled children between 150 and 200% of poverty. FAPA has cost sharing and benefit limits in accordance with the individual ESI policy.
MN1	The Minnesota State Medicaid Plan details the limitations applied to both Medicaid and S-SCHIP services; limitations may include prior authorization thresholds or define settings in which services must be provided.
MS1	There are no cost sharing requirements for families with income below 150% FPL or for American Indian/Native Alaskan children. There is no copay for preventive services. Families with incomes between 150% and 175% FPL have copays on certain services and pay a maximum out of pocket of $800/calendar year. Families with incomes between 176% and 200% FPL have copays on certain services and pay a maximum out of pocket of $950/calendar year.
NJ1	New Jersey has three S-SCHIP programs: Plans B, C and D. Plan B offers coverage to children in families with gross incomes between 133 and 150% of poverty; Plan C covers children between 151 and 200% of poverty; and Plan D covering children between 201 and 350% of poverty.
NM1	There is no copay for services through the Indian Health Service (IHS).
OR1	Outpatient services medically necessary for the treatment of health condition and treatment pairs listed on the OHP Prioritized List and funded by the State of Oregon Legislature are covered. Some non-emergency outpatient hospital services provided by managed care plans may be subject to limitations and/or prior authorization. Fee-for-service, non-emergency outpatient hospital services may be subject to limitations and/or prior authorizations as documented in OMAP's Hospital Services for the Oregon Health Plan Guide.
OR2	Physician's services necessary to diagnose any medical condition are covered. Once a condition is diagnosed, physician services are limited to those services that are medically necessary for the treatment of health condition and treatment pairs listed on the OHP Prioritized listed and funded by the State of Oregon Legislature. Fee-for-service, physician services may be subject to limitations and/or prior authorizations as documented in OMAP's Medical-Surgical Services Guide.
OR3	Clinic services that are medically necessary for the treatment of health condition and treatment pairs listed on the OHP Prioritized listed and funded by the State of Oregon Legislature are covered.
RI1	Cost sharing is only for families with income in excess of 185% of poverty if they elected a coinsurance rather than a premium option.

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TABLE C.1 *(continued)*

UT1	Plan A applies to enrollees at or below 150% of poverty; Plan B applies to enrollees between 150 and 200% of poverty.
VA1	Covers outpatient hospital services that allow one to return home the same day that medical care is rendered.
VA2	Covers physician's services both in the hospital and in the doctor's office. Most visits to the physician's office are not limited; however, a referral is needed to see someone other than PCP.
VA3	Covers services provided in local health departments or other clinics licensed by Virginia.
WV1	Outpatient hospital services are limited to pre-scheduled laboratory and diagnostic tests and treatments, when ordered by a physician.
WI1	Wisconsin cost sharing is for adults only and is not required from those served through managed care.

TABLE C.2

BENEFIT LIMITS AND COST SHARING FOR DENTAL SERVICES UNDER SCHIP

State	Program Type	Preventive Dental Services		Restorative Dental Services	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
Alabama	S-SCHIP	2 cleanings and check-ups per year; $1,000 each calendar year	No cost sharing	$1,000 each calendar year	$5 copay
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Alaska	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Arkansas	M-SCHIP	$250 per month; 1 prophylaxis and fluoride per state fiscal year; may be extended based on medical necessity	No cost sharing	Requires prior authorization based on medical necessity	No cost sharing
Arizona	S-SCHIP	Limited to routine, preventive, therapeutic and emergency services; dentures and dental devices are covered if authorized in consultation with a dentist	No cost sharing	No benefit limits	No cost sharing
California	S-SCHIP (CA1)	No benefit limits (a)	No cost sharing	No benefit limits (a)	Copay for micro-filled resin restorations (copay not specified)
	M-SCHIP	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits
Colorado	S-SCHIP	Service not covered	Service not covered	Service not covered	Service not covered
Connecticut	S-SCHIP	No benefit limits	No cost sharing	$50 allowance per procedure within continuous eligibility period; $250 total limit per continuous eligibility period; procedures include bridges/crowns, root canals, full or partial dentures, or extractions; $725 annual allowance on orthodontia and client is responsible for remaining dollars	Copay based on procedure
	M-SCHIP	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits
Delaware	S-SCHIP	Service not covered	Service not covered	Service not covered	Service not covered
District of Columbia	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing

TABLE C.2 *(continued)*

State	Program Type	Preventive Dental Services		Restorative Dental Services	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
Florida	S-SCHIP (FL1)	Healthy Kids - Service not covered MediKids and CMS - Oral prophylaxis and fluoride treatments limited to one per six months; sealants limited to one per three years per tooth	Healthy Kids - Service not covered MediKids and CMS - No cost sharing	Healthy Kids - Service not covered MediKids and CMS - Oral surface posterior resins limited to one per three years	Healthy Kids - Service not covered MediKids and CMS - No cost sharing
	M-SCHIP	2 cleanings per year; 2 fluoride treatments per year; sealants limited to one per three years per tooth	No cost sharing	Oral surface posterior resins limited to one per three years	No cost sharing
Georgia	S-SCHIP	2 visits per year for dental exams and screenings; 2 emergency exams per year (must be during office hours)	No cost sharing	One restorative procedure per tooth per restoration; sealant for first and second permanent molars only; orthodontics with prior approval only	No cost sharing
Hawaii	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Idaho	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Illinois	S-SCHIP (IL1)	No benefit limits	No cost sharing	No benefit limits	KidCare Share - $2 per visit KidCare Premium - $5 per visit
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Indiana	S-SCHIP	(c)	(c)	(c)	(c)
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Iowa	S-SCHIP (IA1)	Wellmark Plan - $1,000 per year; 2 oral evaluations per year; 2 cleanings per year; 1 yearly topical fluoride application; 1 bitewing x-ray per year; full mouth x-ray once every 5 consecutive years; occlusal and extraoral x-rays once per year For children under 15 only - Sealant permanent first and second molars once per lifetime; space maintainers for missing back teeth Iowa Health Solutions - $1,500 per year	No cost sharing	Wellmark Plan - $1,000 per year; covered services include emergency treatment (palliative), restoration of decayed or fractured teeth, routine oral surgery, pulpotomy, retrograde fillings, root canal therapy, crowns, inlays, onlays, posts and cores (IA2) Iowa Health Solutions - $1,500 per year	No cost sharing

TABLE C.2 *(continued)*

State	Program Type	Preventive Dental Services		Restorative Dental Services	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
Iowa (con't)	M-SCHIP	2 oral evaluations per year; 2 cleanings per year; 2 fluoride treatments per year (part of cleaning); 1 bitewing x-ray per year For children through age 15 - Sealant permanent first and second molars once per lifetime (this will be increased to 18 years with a pending rule change.) (IA3)	No cost sharing	Covered services include treatment of new cavities, not older cavities; amalgam alloy and composite restoration once every 2 years; porcelain crowns two per year; no limit to stainless steel crowns (noble metals are covered when the patient is allergic to all other restorative materials) (IA4)	No cost sharing
Kansas	S-SCHIP	No benefit limits	No cost sharing	Orthodontics not covered	No cost sharing
Kentucky	S-SCHIP	1 cleaning per year (KY1)	No cost sharing	No benefit limits (KY1)	No cost sharing
	M-SCHIP	1 cleaning per year (KY1)	No cost sharing	No benefit limits (KY1)	No cost sharing
Louisiana	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Maine	S-SCHIP	No benefit limits	No cost sharing	Orthodontics require prior authorization	No cost sharing
	M-SCHIP	No benefit limits	No cost sharing	Orthodontics require prior authorization	No cost sharing
Maryland	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Massachusetts	S-SCHIP (MA1)	No benefit limits	No cost sharing	No benefit limits	No cost sharing
	M-SCHIP	No benefit limits	No cost sharing	Service not covered	Service not covered
Michigan	S-SCHIP	2 visits per year; $600 per year	No cost sharing	$600 per year	No cost sharing
	M-SCHIP	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing
Minnesota	M-SCHIP	Limitations apply (not specified) (MN1)	No cost sharing	Limitations apply (not specified) (MN1)	No cost sharing
Mississippi	S-SCHIP	No benefit limits	No cost sharing	Only cover procedures that result of accidental injury	No cost sharing
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Missouri	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Montana	S-SCHIP	Service not covered	Service not covered	Service not covered	Service not covered
Nebraska	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Nevada	S-SCHIP	No benefit limits	No cost sharing	Orthodontics require prior approval; more than seven steel crowns in one visit require prior authorization	No cost sharing
New Hampshire	S-SCHIP	2 oral exams per year; 2 cleanings per year; 1 fluoride per year; 1 bitewing x-ray per year (others as needed) ; panoramic x-rays ever 3 years; space maintainers, sealants once per lifetime for permanent teeth only; $500 per year	No cost sharing	Cover fillings only; $500 per year	No cost sharing

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TABLE C.2 *(continued)*

State	Program Type	Preventive Dental Services		Restorative Dental Services	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
New Hampshire (con't)	M-SCHIP (NH1)	Service not covered	Service not covered	Service not covered	Service not covered
New Jersey	S-SCHIP (NJ1)	Plan B and C - No benefit limits Plan D - Limited to children under 12 years	No cost sharing	Plan B and C - No benefit limits Plan D - Service not covered	Plan C - $5 copay Plan D - Service not covered
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
New Mexico	M-SCHIP	No benefit limits	<185% of FPL - No copay 185 to 235% of FPL - $5 copay (NM1)	No benefit limits	<185% of FPL - No copay 185 to 235% of FPL - $5 copay (NM1)
New York	S-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
North Carolina	S-SCHIP	Limited to cleaning and scaling, fillings, sealants, and fluoride treatments every 6 months	No cost sharing	Limited to simple tooth pulling (pulling impacted teeth are not covered), removal of part of the nerve (pulpotomy and stainless steel crowns)	No cost sharing
North Dakota	S-SCHIP	(c)	(c)	(c)	(c)
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Ohio	M-SCHIP	2 exams per year; screenings performed as a component of the EPSDT benefit	No cost sharing	No benefit limits	No cost sharing
Oklahoma	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Oregon	S-SCHIP	Limited to oral prophylaxis, radiographs, topical fluoride and sealants	No cost sharing	Limited to restorations for primary and permanent teeth using amalgam, composite materials and stainless steel or polycarbonate crowns	No cost sharing
Pennsylvania	S-SCHIP	No benefit limits	No cost sharing	2 exams per year	No cost sharing
Rhode Island	M-SCHIP	No benefit limits	No cost sharing	No benefit limits (b)	No cost sharing
South Carolina	M-SCHIP	No benefit limits	No cost sharing	No benefit limits (a)	No cost sharing
South Dakota	S-SCHIP	(c)	(c)	(c)	(c)
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits (a)	No cost sharing
Tennessee	M-SCHIP	No benefit limits	No cost sharing	No benefit limits (a)	No cost sharing
Texas	S-SCHIP	(c)	(c)	(c)	(c)
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Utah	S-SCHIP (UT1)	Limited to cleaning, exam, bitewing x-rays, fluoride, and sealants	No cost sharing	Limited to fillings, space maintainers, pulpotomies, and extractions	Plan B - 20% copay
Vermont	S-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing

TABLE C.2 *(continued)*

State	Program Type	Preventive Dental Services		Restorative Dental Services	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
Virginia	S-SCHIP	Limited to preventive and emergency	No cost sharing	Limited to orthodontics, crowns, etc. when prescribed by a dentist and authorized by DMAS	No cost sharing
Washington	S-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
West Virginia	S-SCHIP	No benefit limits	No cost sharing	Orthodontics require prior authorization	No cost sharing
	M-SCHIP	No benefit limits	No cost sharing	Crowns if medically necessary (b)	No cost sharing
Wisconsin	M-SCHIP	No benefit limits	No cost sharing (WI1)	No benefit limits	No cost sharing (WI1)
Wyoming	S-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations, Section 3.2.1 of the State Evaluation Framework.

(a) Service must be medically necessary.

(b) Prior approval required.

(c) Program not implemented at time of title XXI State Evaluation.

CA1 Services provided to children with special needs through CCS and CMH are provided at no cost.

FL1 Florida has three S-SCHIP programs: Healthy Kids, MediKids, and CMS. Healthy Kids covers children 5 - 19 years between 101 and 200% of poverty. (In some counties younger siblings may be covered in HealthyKids.) MediKids covers children from birth to age five; the income levels vary according to a child's age, but the threshold is 200% of poverty. CMS offers coverage for disabled children from birth to 19; the income levels vary according to a child's age, but the threshold is 200% of poverty.

IL1 Illinois has two S-SCHIP programs: KidCare Share and KidCare Premium. KidCare Share covers children between 134 and 150% of poverty; KidCare Premium covers children between 151 and 185% of poverty. The annual copayment maximum is $100 per family. Families with American Indian or Alaska Native children do not pay premiums or copays.

IA1 Iowa's S-SCHIP program offers services under the Wellmark Plans (Wellmark Classic Blue (Indemnity) and Wellmark Unity Choice (HMO)) and the Iowa Health Solutions Health Plan (HMO).

IA2 Other restorative dental services covered under the Wellmark Plan include: contour of bone (alveoloplasty), general anesthesia/sedation, restoration of decayed or fractured teeth, limited occlusal adjustment, routine oral surgery, endodontic services, apicoectomy/periradicular surgery, direct pulp cap, pulpotomy, retrograde fillings, root canal therapy. Also covered are periodontal services: 1) conservative periodontal procedures (root plaining and scaling)—once every 24 consecutive months for each quadrant; 2) complex periodontal procedures—once every 3 consecutive year for each quadrant of the mouth; 3) periodontal maintenance therapy—must follow conservative or complex periodontal therapy—up to 4 times/12 month period & then once every 6 months.

TABLE C.2 *(continued)*

IA3	Other services covered under Iowa's M-SCHIP benefits include the following diagnostic services: 1) oral evaluation once per patient per dentist. (This will be changed to once per patient per dentist in a 3 year period with a pending rule change); 2) complete mouth x-ray survey consisting of a minimum of 14 periapical films and bite-wings films is covered once every five years, unless otherwise medically necessary (not covered under the age of six); 3) intraoral and extraoral films are covered when necessary to diagnose a condition. In addition, cleanings for persons with a physical or mental disability are not limited and are covered as needed. Sealant benefits will be expanded to children less than 18 years.
IA4	Iowa M-SCHIP offers the following endodontic services: root canal treatments are covered for permanent anterior and posterior teeth when extensive post treatment restorative procedures are not necessary and when missing teeth do not jeopardize the integrity or function of the dental arches. Oral surgery is covered for 1) surgical and non-surgical extractions if medically necessary; 2) general anesthesia and intravenous sedation are covered when the extensiveness of the procedure indicates it or there is a disease or impairment, which warrants its use; 3) additional payment for postoperative care is covered when the need is beyond normal follow up care or the original service was performed by another dentist. Prosthetic Services include 1) removable partial dentures for front teeth are covered once every five years unless lost, stolen, broken beyond repair or no longer fit; 2) removable partial dentures for posterior teeth require prior approval and are covered when fewer than eight posterior teeth are in occlus.
KY1	The Medicaid provider network must provide all benefits. Primary care provider referrals are required for some services provided through managed care.
MA1	Massachusetts has three different S-SCHIP programs: Family Assistance Direct Coverage (FADC) is the state's separate S-SCHIP for children 1 to 18 years between 150 and 200% of poverty; Family Assistance Premium Assistance (FAPA) is an employer buy-in program for those with access to employer-sponsored (ESI) insurance between 150 and 200% of poverty; and CommonHealth (CH) is a program for disabled children between 150 and 200% of poverty. FAPA has cost sharing and benefit limits in accordance with the individual ESI policy.
MN1	The Minnesota State Medicaid Plan details the limitations applied to both Medicaid and S-SCHIP services; limitations may include prior authorization thresholds or define settings in which services must be provided.
NH1	New Hampshire M-SCHIP program is for infants only.
NJ1	New Jersey has three S-SCHIP programs: Plans B, C and D. Plan B offers coverage to children in families with gross incomes between 133 and 150% of poverty; Plan C covers children between 151 and 200% of poverty; and Plan D covering children between 201 and 350% of poverty.
NM1	There is no copay for services through the Indian Health Service (IHS).
UT1	Plan A applies to enrollees at or below 150% of poverty; Plan B applies to enrollees between 150 and 200% of poverty.
WI1	Wisconsin cost sharing is for adults only and is not required from those served through managed care.

TABLE C.3

BENEFIT LIMITS AND COST SHARING FOR PRESCRIPTION DRUGS UNDER SCHIP

State	Program Type	Benefit Limits	Cost Sharing
Alabama	S-SCHIP	No benefit limits	100 to 150% FPL - No cost sharing 151 to 200% FPL - $1 copay for generic drugs (mandatory if available); $3 copay for brand name drugs
	M-SCHIP	No benefit limits	For 18-year-olds, $.50, $1, $3 copays based on price of prescription
Alaska	M-SCHIP	No benefit limits	For 18-year-olds, $2 per prescription (AK1)
Arkansas	M-SCHIP	With physician prescription, no limit	No cost sharing
Arizona	S-SCHIP	No benefit limits	No cost sharing
California	S-SCHIP	No benefit limits (a)	$5 copay unless provided in inpatient setting
	M-SCHIP	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits
Colorado	S-SCHIP	No benefit limits	101 to 150% FPL - $1 copay 151 to 185% FPL - $3 copay for generic 151 to 185% FPL - $5 copay for brand name
Connecticut	S-SCHIP	No benefit limits	Generic - $3 copay Oral contraceptives - $ 5 copay Brand name - $6 copay
	M-SCHIP	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits
Delaware	S-SCHIP	No benefit limits	No cost sharing
District of Columbia	M-SCHIP	No benefit limits	No cost sharing
Florida	S-SCHIP (FL1)	No benefit limits	Healthy Kids - $3 per prescription; 31-day supply CMS, MediKids - No cost sharing
	M-SCHIP	No benefit limits	No cost sharing
Georgia	S-SCHIP	Prescriptions or refills limited to six drugs per month; some drugs require prior approval or have therapy limitations.	No cost sharing
Hawaii	M-SCHIP	No benefit limits	No cost sharing
Idaho	M-SCHIP	No benefit limits	No cost sharing

Table C.3 *(continued)*

State	Program Type	Benefit Limits	Cost Sharing
Illinois	S-SCHIP (IL1)	No benefit limits	KidCare Share - $2 per prescription (1-30-day supply) KidCare Premium - $3 copay for generic or $5 for brand name (1-30-day supply)
	M-SCHIP	No benefit limits	No cost sharing
Indiana	S-SCHIP	(b)	(b)
	M-SCHIP	No benefit limits	No cost sharing
Iowa	S-SCHIP (IA1)	Wellmark Plan - Uses preferred drug list, maximum quantity of medication: 1. Retail prescriptions - a 30-day supply or 100 units, whichever is less 2. Retail maintenance prescriptions - a 30-day supply 3. Mail Order Prescriptions - a 30-day supply Iowa Solutions Plan - 1. Each prescription is limited to a maximum of a 30-day supply 2. Must use generic drugs unless approved alternative to brand name drugs is not available or the prescribing physician has indicated "no generic substitution." If patient otherwise obtains a brand name drug, patient is responsible for the difference of cost 3. Drugs purchased for future use limited to three month supply or a maximum quantity for maintenance legend drugs of a 100-unit dose, whichever is less 4. Non-prescription drugs and drugs prescribed primarily for cosmetic use are not covered	Wellmark Plan - No cost sharing if generic drugs are used, provided a generic equivalent is available; brand name drugs are covered if a generic equivalent is not available Iowa Solutions Plan - No cost sharing unless a patient otherwise requests and obtains a brand name drug; in that case, the patient is responsible for the difference of cost
	M-SCHIP	No benefit limits	No cost sharing
Kansas	S-SCHIP	No benefit limits (a)	No cost sharing
Kentucky	S-SCHIP	Coverage of drugs contained on drug list that are prescribed by a legally authorized health care prescriber	No cost sharing
	M-SCHIP	Coverage of drugs contained on drug list that are prescribed by a legally authorized health care prescriber	No cost sharing
Louisiana	M-SCHIP	No benefit limits	No cost sharing
Maine	S-SCHIP	Limited to FDA approved or indicated only	No cost sharing
	M-SCHIP	Limited to FDA approved or indicated only	No cost sharing

Table C.3 *(continued)*

State	Program Type	Benefit Limits	Cost Sharing
Maryland	M-SCHIP	No benefit limits	No cost sharing
Massachusetts	S-SCHIP (MA1)	No benefit limits	No cost sharing
	M-SCHIP	No benefit limits	No cost sharing
Michigan	S-SCHIP	No benefit limits (a)	No cost sharing
	M-SCHIP	No benefit limits (a)	No cost sharing
Minnesota	M-SCHIP	Limitations apply (not specified) (MN1)	No cost sharing
Mississippi	S-SCHIP	No benefit limits	No cost sharing
	M-SCHIP	No benefit limits	No cost sharing
Missouri	M-SCHIP	Must be prescribed by a physician	226 to 300% FPL - $5 copay
Montana	S-SCHIP	No benefit limits	>100% FPL - $3 for generic; $5 for brand name
Nebraska	M-SCHIP	No benefit limits	No cost sharing
Nevada	S-SCHIP	No benefit limits	No cost sharing
New Hampshire	S-SCHIP	90-day supply available by mail order	$5 copay for generic $10 copay for brand name
	M-SCHIP	No benefit limits	No cost sharing
New Jersey	S-SCHIP (NJ1)	No benefit limits	Plan C - $1 copay for generic; $5 copay for brand name Plan D - $5 copay and $10 copay if more than 34 -day supply given
	M-SCHIP	No benefit limits	No cost sharing
New Mexico	M-SCHIP	No benefit limits	<185% of FPL - No copay 185 to 235% of FPL - $2 copay (NM1)
New York	S-SCHIP	May be limited to generic medications	No cost sharing
	M-SCHIP	M-SCHIP prescription drug benefits not reported	M-SCHIP prescription drug benefits not reported
North Carolina	S-SCHIP	No benefit limits	> 151% FPL - $6 copay
North Dakota	S-SCHIP	(b)	(b)
	M-SCHIP	No benefit limits	No cost sharing
Ohio	M-SCHIP	Drugs not contained in the Ohio Medicaid Drug Formulary can be requested through the prior or post authorization process	No cost sharing
Oklahoma	M-SCHIP	No benefit limits	No cost sharing

Table C.3 *(continued)*

State	Program Type	Benefit Limits	Cost Sharing
Oregon	S-SCHIP	Coverage of prescription drugs medically necessary for the treatment of health condition and treatment pairs listed on the OHP prioritized listed and funded by the State of Oregon Legislature (OR1)	No cost sharing
Pennsylvania	S-SCHIP	No benefit limits	No cost sharing
Rhode Island	M-SCHIP	May be limited to formulary	$2 per prescription (RI1)
South Carolina	M-SCHIP	No benefit limits	No cost sharing
South Dakota	S-SCHIP	(b)	(b)
	M-SCHIP	No benefit limits	No cost sharing
Tennessee	M-SCHIP	No benefit limits (a)	No cost sharing
Texas	S-SCHIP	(b)	(b)
	M-SCHIP	No benefit limits	No cost sharing
Utah	S-SCHIP (UT1)	No benefit limits	Plan A - $2 copay Plan B - $4 copay or 50% coinsurance for brand name drugs not on approved list
Vermont	S-SCHIP	No benefit limits	No cost sharing
Virginia	S-SCHIP	Limited to drugs ordered by a physician and on the CMSIP formulary	No cost sharing
Washington	S-SCHIP	No benefit limits	$5 for brand name
West Virginia	S-SCHIP	Mandatory generic substitution, including oral contraceptives	No cost sharing
	M-SCHIP	No benefit limits	No cost sharing
Wisconsin	M-SCHIP	No benefit limits	No cost sharing (WI1)
Wyoming	S-SCHIP	No benefit limits	No cost sharing

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations, Section 3.2.1 of the State Evaluation Framework.

(a) Service must be medically necessary.
(b) Program not implemented at time of title XXI State Evaluation.

AK1 Cost sharing for 18-year-olds apply only to 18-year-olds that are not pregnant or Alaska Natives.

Table C.3 *(continued)*

FL1	Florida has three S-SCHIP programs: Healthy Kids, MediKids, and CMS. Healthy Kids covers children 5 - 19 years between 101 and 200% of poverty. (In some counties younger siblings may be covered in HealthyKids.) MediKids covers children from birth to age five; the income levels vary according to a child's age, but the threshold is 200% of poverty. CMS offers coverage for disabled children from birth to 19; the income levels vary according to a child's age, but the threshold is 200% of poverty.
IL1	Illinois has two S-SCHIP programs: KidCare Share and KidCare Premium. KidCare Share covers children between 134 and 150% of poverty; KidCare Premium covers children between 151 and 185% of poverty. The annual copayment maximum is $100 per family. Families with American Indian or Alaska Native children do not pay premiums or copays.
IA1	Iowa's S-SCHIP program offers services under the Wellmark Plans (Wellmark Classic Blue (Indemnity) and Wellmark Unity Choice (HMO)) and the Iowa Health Solutions Health Plan (HMO).
MA1	Massachusetts has three different S-SCHIP programs: Family Assistance Direct Coverage (FADC) is the state's separate S-SCHIP for children 1 to 18 years between 150 and 200% of poverty; Family Assistance Premium Assistance (FAPA) is an employer buy-in program for those with access to employer-sponsored (ESI) insurance between 150 and 200% of poverty; and CommonHealth (CH) is a program for disabled children between 150 and 200% of poverty. FAPA has cost sharing and benefit limits in accordance with the individual ESI policy.
MN1	The Minnesota State Medicaid Plan details the limitations applied to both Medicaid and S-SCHIP services; limitations may include prior authorization thresholds or define settings in which services must be provided.
NJ1	New Jersey has three S-SCHIP programs: Plans B, C and D. Plan B offers coverage to children in families with gross incomes between 133 and 150% of poverty; Plan C covers children between 151 and 200% of poverty; and Plan D covering children between 201 and 350% of poverty.
NM1	There is no copay for services through the Indian Health Service (IHS).
RI1	Cost sharing is only for families with income in excess of 185% of poverty if they elected a coinsurance rather than a premium option.
OR1	Some prescriptions may require prior authorization either by the health plan (for managed care enrollees) or by the Office of Medical Assistance Programs (for fee-for-service clients).
UT1	Plan A applies to enrollees at or below 150% of poverty; Plan B applies to enrollees between 150 and 200% of poverty.
WI1	Wisconsin cost sharing is for adults only and is not required from those served through managed care.

TABLE C.4

BENEFIT LIMITS AND COST SHARING FOR MENTAL HEALTH TREATMENT UNDER SCHIP

State	Program Type	Inpatient Mental Health Services		Outpatient Mental Health Services	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
Alabama	S-SCHIP	30 days each calendar year	100 to150% FPL - No cost sharing 151 to 200% FPL - $5 copay	20 visits each calendar year	No cost sharing
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Alaska	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Arkansas	M-SCHIP	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing
Arizona	S-SCHIP	30 days per contract year (limit includes inpatient substance abuse care) (AZ1, AZ2)	No cost sharing	30 visits per contract year (limit includes outpatient substance abuse services) (AZ2)	No cost sharing
California	S-SCHIP (CA1)	30 days per benefit year (a)	No cost sharing	20 visits per benefit year (a)	$5 copay
	M-SCHIP	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits
Colorado	S-SCHIP	45 days	No cost sharing	20 visit limit; neurobiologically based mental illnesses are treated as any other illness and not subject to this limit	< 101%FPL - No copay 101 to 150% FPL - $2 copay 151 to 185% FPL - $5 copay
Connecticut	S-SCHIP	60 days, exchangeable with alternate levels of care; due to mental health parity enacted in January 2000, only mental retardation, learning, motor skills, communication and caffeine related disorders, and relational problems have the noted limitations	No cost sharing	30 visits per calendar year; due to mental health parity enacted in January 2000, only mental retardation, learning, motor skills, communication and caffeine related disorders, and relational problems have the noted limitations (CT1)	Visits 1 to 10 - No copay Visits 11 to 20 - $25 copay Visits 21 to 30 - Lesser of $50 copay or 50%

Table C.4 *(continued)*

State	Program Type	Inpatient Mental Health Services		Outpatient Mental Health Services	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
Connecticut (con't)	M-SCHIP	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits
Delaware	S-SCHIP	31 days	No cost sharing	30 days	No cost sharing
District of Columbia	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Florida	S-SCHIP (FL1)	Healthy Kids - No benefit limits. MediKids and CMS - No benefit limits (b)	No cost sharing	No benefit limits (FL2)	Healthy Kids - $3 per visit MediKids and CMS – No cost sharing
	M-SCHIP	No benefit limits (b)	No cost sharing	No benefit limits (FL2)	No cost sharing
Georgia	S-SCHIP	30 days per admission; cover acute care hospital only (GA1)	No cost sharing	24 hours per calendar year for licensed applied psychologists; 12 hours per calendar year for psychiatrists (GA2)	No cost sharing
Hawaii	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Idaho	M-SCHIP	No benefit limits	No cost sharing	Limits by clinic or rehab option and by service category (limits not specified)	No cost sharing
Illinois	S-SCHIP (IL1)	No benefit limits	Kid Care Share - $2 per admission Kid Care Premium - $5 per admission	No benefit limits	Kid Care Share - $2 per visit Kid Care Premium - $5 per visit
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Indiana	S-SCHIP	(c)	(c)	(c)	(c)
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Iowa	S-SCHIP (IA1)	Wellmark Plan - 30 days per year (limit includes inpatient substance abuse care) Iowa Health Solutions - 60 days per calendar year	No cost sharing	Wellmark Plan - 30 visits per year (limit includes outpatient substance abuse services) Iowa Health Solutions - 20 visits per calendar year	No cost sharing
	M-SCHIP	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing
Kansas	S-SCHIP	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing

Table C.4 *(continued)*

State	Program Type	Inpatient Mental Health Services		Outpatient Mental Health Services	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
Kentucky	S-SCHIP	No benefit limits (a) (KY1,KY2)	No cost sharing	No benefit limits (a) (KY1)	No cost sharing
	M-SCHIP	No benefit limits (a) (KY1, KY2)	No cost sharing	No benefit limits (a) (KY1)	No cost sharing
Louisiana	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Maine	S-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Maryland	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Massachusetts	S-SCHIP (MA1)	FADC and CH plans - No benefit limits FAPA- 60 days in psychiatric hospital; unlimited days in general hospital.	No cost sharing	FADC and CH plans - No benefit limits FAPA - 20 visits or $500 per calendar year	No cost sharing
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Michigan	S-SCHIP	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing
	M-SCHIP	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing
Minnesota	M-SCHIP	Limitations apply (not specified) (MN1)	No cost sharing	Limitations apply (not specified) (MN1)	No cost sharing
Mississippi	S-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
	M-SCHIP	No benefit limits	No cost sharing	52 visits per year	No cost sharing
Missouri	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Montana	S-SCHIP	21 days per benefit year (limit includes inpatient substance abuse care); partial hospitalization services exchanged for inpatient days at a rate of 1 inpatient day for 2 partial treatment days (MT1)	>100% FPL - $25 copay	20 visits per benefit year (MT1)	>100% FPL - $5 copay
Nebraska	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Nevada	S-SCHIP	No benefit limits (NV1)	No cost sharing	No benefit limits	No cost sharing

Table C.4 *(continued)*

State	Program Type	Inpatient Mental Health Services		Outpatient Mental Health Services	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
New Hampshire	S-SCHIP	15 days per calendar year	No cost sharing	20 visits per calendar year	No cost sharing
	M-SCHIP (NH1)	Service not covered	Service not covered	Service not covered	Service not covered
New Jersey	S-SCHIP (NJ1)	Plan B and C - No benefit limits Plan D - 35 days in 365 day span; can exchange 1 inpatient day for 4 outpatient days or 2days of partial hospitalization	No cost sharing	Plan B and C - No benefit limits Plan D - 20 visits in a 365 day consecutive span; services must be evaluative and crisis intervention or home health	Plan B and C - No cost sharing Plan D - $25 copay
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits (NJ3)	No cost sharing
New Mexico	M-SCHIP	No benefit limits	<185% FPL - No copay 185 to 235% FPL - $25 copay (NM1)	No benefit limits	<185% FPL - No copay 185 to 235% FPL - $5 copay (NM1)
New York	S-SCHIP	30 days per calendar year (limit includes inpatient substance abuse care)	No cost sharing	60 visits per year (limit includes outpatient substance abuse care)	No cost sharing
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
North Carolina	S-SCHIP	No benefit limits (b)	No cost sharing	26 visits covered in plan year without prior approval; over 26 visits covered if approved in advance by the mental health case manager	No cost sharing
North Dakota	S-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Ohio	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Oklahoma	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Oregon	S-SCHIP	Condition and treatment pairs must be listed on the OHP Prioritized List (0R1)	No cost sharing	Condition and treatment pairs must be listed on the OHP Prioritized List (0R2)	No cost sharing
Pennsylvania	S-SCHIP	90 days per year in conjunction with limit on inpatient hospital services	No cost sharing	50 visits per year	No cost sharing
Rhode Island	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing

Table C.4 *(continued)*

State	Program Type	Inpatient Mental Health Services		Outpatient Mental Health Services	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
South Carolina	M-SCHIP	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing
South Dakota	S-SCHIP	(c)	(c)	(c)	(c)
	M-SCHIP	No benefit limits (b)	No cost sharing	Unlimited visits with physicians and community health centers; limited to 40 hours of individual therapy from other professionals in a 12-month period	No cost sharing
Tennessee	M-SCHIP	No benefit limits (b)	No cost sharing	No benefit limits (b)	No cost sharing
Texas	S-SCHIP	(c)	(c)	(c)	(c)
	M-SCHIP	No benefit limits (b)	No cost sharing	30 visits per calendar year; prior authorization required for more than 30 visits	No cost sharing
Utah	S-SCHIP (UT1)	30 days per plan year (limits include inpatient substance abuse care)	Plan A - No cost sharing Plan B - Patient pays 10% of stay for first 10 days, 50% for next 20 days	30 visits per plan year (limits include outpatient substance abuse care)	Plan A - $5 copay per visit Plan B - 50% coinsurance per visit
Vermont	S-SCHIP	No benefit limits (b)	No cost sharing	No benefit limits	No cost sharing
Virginia	S-SCHIP	Cover acute care hospital only (VA1)	No cost sharing	No benefit limits (VA2)	No cost sharing
Washington	S-SCHIP	Limited through Regional Support Networks(limits not specified)	No cost sharing	Limited through Regional Support Networks(limits not specified)	No cost sharing
West Virginia	S-SCHIP	30 days per lifetime for inpatient care; 60 visits per lifetime for partial hospitalization and day programs	No cost sharing	26 visits per 12-month coverage period	No cost sharing
	M-SCHIP	No benefit limits	No cost sharing	Service limits apply (limits not specified)	No cost sharing
Wisconsin	M-SCHIP	No benefit limits	No cost sharing (WI1)	No benefit limits	No cost sharing (WI1)
Wyoming	S-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing

Table C.4 *(continued)*

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations, Section 3.2.1 of the State Evaluation Framework.

(a) Service must be medically necessary.

(b) Prior approval required.

(c) Program not implemented at time of title XXI State Evaluation.

AZ1 Applicants in an Institution for Mental Disease (IMD) at the time of application are excluded from enrollment in Kids Care.

AZ2 Only psychiatrists, psychologist, psychiatric nurse practitioners may bill independently for behavioral health services. Other behavioral health professionals and behavioral health technicians shall be affiliated with a qualified agency, and services provided by these individuals shall be billed through that agency.

CA1 Children with special needs receive services through CCS and CMH at no cost.

CT1 For outpatient mental health services, Connecticut offers supplemental coverage under Husky Plus.

FL1 Florida has three S-SCHIP programs: Healthy Kids, MediKids, and CMS. Healthy Kids covers children 5 - 19 years between 101 and 200% of poverty. (In some counties younger siblings may be covered in HealthyKids.) MediKids covers children from birth to age five; the income levels vary according to a child's age, but the threshold is 200% of poverty. CMS offers coverage for disabled children from birth to 19; the income levels vary according to a child's age, but the threshold is 200% of poverty.

FL2 In Florida Medicaid, MediKids, and CMS, outpatient mental health services must be provided by participating community health providers. Hospital outpatient services must be provided by a physician.

GA1 Services furnished in a state-operated mental hospital are not covered. Services furnished in an Institution for Mental Diseases (IMD) are not covered. Residential or other 24-hour therapeutically planned structural services are covered only through the DHR Match Program.

GA2 Services are covered through Community Mental Health Centers, subject to limitations specified in DHR standards.

IL1 Illinois has two S-SCHIP programs: KidCare Share and KidCare Premium. KidCare Share covers children between 134 and 150% of poverty; KidCare Premium covers children between 151 and 185% of poverty. The annual copayment maximum is $100 per family. Families with American Indian or Alaska Native children do not pay premiums or copays.

IA1 Iowa's S-SCHIP program offers services under the Wellmark Plans (Wellmark Classic Blue (Indemnity) and Wellmark Unity Choice (HMO)) and the Iowa Health Solutions Health Plan (HMO).

KY1 The Medicaid provider network must provide all benefits. Primary care provider referrals are required for some services provided through managed care.

KY2 Inpatient mental health services require prior authorization and concurrent review. This applies to Acute Psychiatric Hospitals and PRTF. The pre-set criteria were established by Department for Medicaid Services.

MA1 Massachusetts has three different S-SCHIP programs: Family Assistance Direct Coverage (FADC) is the state's separate S-SCHIP for children 1 to 18 years between 150 and 200% of poverty; Family Assistance Premium Assistance (FAPA) is an employer buy-in program for those with access to employer-sponsored (ESI) insurance between 150 and 200% of poverty; and CommonHealth (CH) is a program for disabled children between 150 and 200% of poverty. FAPA has cost sharing and benefit limits in accordance with the individual ESI policy.

Table C.4 *(continued)*

MN1	The Minnesota State Medicaid Plan details the limitations applied to both Medicaid and S-SCHIP services; limitations may include prior authorization thresholds or define settings in which services must be provided.
MT1	Prior to July 1, 1999, CHIP enrollees with mental health needs beyond the coverage provided by SCHIP and diagnosed as seriously emotionally disturbed were eligible for Montana's Mental Health Access Plan (MHAP). MHAP was a comprehensive managed care program that provided mental health care to Montana children who were seriously emotionally disturbed. MHAP had no coverage limits beyond medical necessity. MHAP paid the mental health benefits for children enrolled in SCHIP and MHAP. Effective July 1, 1999, Montana's mental health system changed from MHAP to the Mental Health Services Plan (MHSP), a fee-for-service plan administered by the Department of Health and Human Services (DPHHS). Children enrolled in SCHIP and MHSP have their mental health benefits paid by SCHIP up to specified limits and then are supplemented by MHSP. SCHIP enrollees with the following disorders are not subject to the limit on covered mental health benefits provided by SCHIP: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, and autism.
NV1	Prior authorization required for Residential Treatment Center placement and extended stays.
NH1	New Hampshire M-SCHIP program is for infants only.
NJ1	New Jersey has three S-SCHIP programs: Plans B, C and D. Plan B offers coverage to children in families with gross incomes between 133 and 150% of poverty; Plan C covers children between 151 and 200% of poverty; and Plan D covering children between 201 and 350% of poverty.
NM1	There is no copay for services through the Indian Health Service (IHS).
OR1	Non-emergency inpatient mental health services require prior authorization of the client's mental health organization (MHO). Residential psychiatric treatment programs are covered.
OR2	According to the MHO's protocols, prior authorization may be required. Psychological services and evaluations are also covered under the state of Oregon's School-Based Health Services Program, as documented in OMAP's School-Based Health Services Guide.
UT1	Plan A applies to enrollees at or below 150% of poverty; Plan B applies to enrollees between 150 and 200% of poverty.
VA1	Services offered in an Institution for Mental Diseases (IMD) are not covered; children in IMDs are not eligible for CMSIP.
VA2	There is no limit if outpatient mental health services are provided by a DMAS-enrolled mental health professional.
WI1	Wisconsin cost sharing is for adults only and is not required from those served through managed care.

TABLE C.5

BENEFIT LIMITS AND COST SHARING FOR SUBSTANCE ABUSE TREATMENT UNDER SCHIP

State	Program Type	Inpatient Substance Abuse Treatment		Residential Substance Abuse Treatment		Outpatient Substance Abuse Treatment	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
Alabama	S-SCHIP	72 hours per episode; 20 days each calendar year	100 to 150% FPL - No cost sharing 151 to 200% FPL - $5 copay	72 hours per episode; 20 days each calendar year	100 to 150% FPL - No cost sharing 151 to 200% FPL - $5 copay	20 visits per calendar year	No cost sharing
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Alaska	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Arkansas	M-SCHIP	Cover acute care hospital only (a)	No cost sharing	Service not covered	Service not covered	Service not covered	Service not covered
Arizona	S-SCHIP	30 days of inpatient care per contract year (limit includes inpatient mental health care); limited to acute detoxification only (AZ1)	No cost sharing	30 days of inpatient care per contract year (limit includes inpatient mental health care); limited to acute detoxification only (AZ1)	No cost sharing	30 visits per contract year in substance abuse rehabilitation agency (limit includes outpatient mental health care) (AZ1)	No cost sharing
California	S-SCHIP (CA1)	No benefit limit (a)	No cost sharing	Service not covered	Service not covered	20 visits per benefit year (a)	$5 copay
	M-SCHIP	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits

Table C.5 *(continued)*

State	Program Type	Inpatient Substance Abuse Treatment		Residential Substance Abuse Treatment		Outpatient Substance Abuse Treatment	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
Colorado	S-SCHIP	Limited to treatment for medical detoxification only	No cost sharing	Service not covered	Service not covered	20 visits per year	< 101% FPL - no copay 101 to 150% FPL - $2 copay 151 to 185% FPL - $5 copay
Connecticut	S-SCHIP	60 days for drug treatment; 45 days for alcohol treatment; due to mental health parity enacted in January 2000, only mental retardation, learning, motor skills, communication and caffeine related disorders, and relational problems have the noted limitations	No cost sharing	Service not covered	Service not covered	60 visits per calendar year; due to mental health parity enacted in January 2000, only mental retardation, learning, motor skills, communication and caffeine related disorders, and relational problems have the noted limitations (CT1)	No cost sharing
	M-SCHIP	Did not report on M-SCHIP benefits	Did not report on M-SCHIP	Did not report on M-SCHIP benefits	Did not report on M-SCHIP	Did not report on M-SCHIP benefits	Did not report on M-SCHIP
Delaware	S-SCHIP	31 days	No cost sharing	31 days	No cost sharing	30 visits	No cost sharing
District of Columbia	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Florida	S-SCHIP (FL1)	Healthy Kids - No benefit limits MediKids and CMS - No benefit limits (b)	No cost sharing	Healthy Kids and CMS - No benefit limits MediKids - Service not covered	Healthy Kids and CMS - No cost sharing MediKids - Service not covered	No benefit limits (FL2)	Healthy Kids - $3 per visit MediKids and CMS - No cost sharing
	M-SCHIP	No benefit limits (b)	No cost sharing	Service not covered	Service not covered	No benefit limits (FL2)	No cost sharing

Table C.5 *(continued)*

State	Program Type	Inpatient Substance Abuse Treatment		Residential Substance Abuse Treatment		Outpatient Substance Abuse Treatment	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
Georgia	S-SCHIP	30 days per admission; cover acute care hospital only (GA1)	No cost sharing	30 days per admission; cover acute care hospital only (GA1)	No cost sharing	Services must be provided in community mental health center; limited per DHR standards	No cost sharing
Hawaii	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Idaho	M-SCHIP	Service not covered	Service not covered	Service not covered	Service not covered	Limits by clinic or rehab option and by service category (limits not specified)	No cost sharing
Illinois	S-SCHIP (IL1)	No benefit limits	KidCare Share - $2 per admission KidCare Premium - $5 per admission	No benefit limits	KidCare Share - $2 per admission KidCare Premium - $5 per admission	No benefit limits	KidCare Share - $2 per visit KidCare Premium - $5 per visit
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits (IL2)		No benefit limits	No cost sharing
Indiana	S-SCHIP	(c)	(c)	(c)	(c)	(c)	(c)
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing

Table C.5 *(continued)*

State	Program Type	Inpatient Substance Abuse Treatment		Residential Substance Abuse Treatment		Outpatient Substance Abuse Treatment	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
Iowa	S-SCHIP (IA1)	Wellmark Plan - 30 days per year (limit includes inpatient mental health care) Iowa Solutions Plan - $9,000 per calendar year; lifetime benefit of $39,000 for inpatient and outpatient substance abuse services	No cost sharing	Service not covered	Service not covered	Wellmark Plan - 30 visits per year (limit includes outpatient mental health care) Iowa Solutions Plan - $1,500 per calendar year for outpatient treatment; $2,500 per calendar year for outpatient counseling; lifetime benefit of $39,000 for inpatient and outpatient substance abuse services	No cost sharing
	M-SCHIP	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing
Kansas	S-SCHIP	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing
Kentucky	S-SCHIP	Cover acute phase of medical detoxification; cover if person meets criteria for Impact Plus Program (program criteria not specified) (KY1)	No cost sharing	Cover if person meets criteria for Impact Plus Program (program criteria not specified) (KY1)	No cost sharing	Cover if person meets criteria for Impact Plus Program (program criteria not specified) (KY1)	No cost sharing
	M-SCHIP	Cover acute phase of medical detoxification and EPSDT Special Services; cover if person meets criteria for Impact Plus Program (program criteria not specified) (KY1)	No cost sharing	Cover EPSDT Special Services or if person meets criteria for Impact Plus Program (program criteria not specified) (KY1)	No cost sharing	Cover EPSDT Special Services or if person meets criteria for Impact Plus Program (program criteria not specified) (KY1)	No cost sharing
Louisiana	M-SCHIP	No benefit limits	No cost sharing	Service not covered	Service not covered	No benefit limits	No cost sharing

Table C.5 *(continued)*

State	Program Type	Inpatient Substance Abuse Treatment		Residential Substance Abuse Treatment		Outpatient Substance Abuse Treatment	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
Maine	S-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	3 hours per week	No cost sharing
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	3 hours per week	No cost sharing
Maryland	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Massachusetts	S-SCHIP (MA1)	FADC and CH plans - No benefit limits FAPA - 30-day annual cap for inpatient rehabilitative care for alcohol and drug abuse; unlimited inpatient detoxification as long as it is medically necessary	No cost sharing	Service not covered	Service not covered	FADC and CH plans - No benefit limits FAPA - 20 visits or $500 per calendar year	No cost sharing
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Michigan	S-SCHIP	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing
	M-SCHIP	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing
Minnesota	M-SCHIP	Limitations apply (not specified) (MN1)	No cost sharing	Limitations apply (not specified) (MN1)	No cost sharing	Limitations apply (not specified) (MN1)	No cost sharing
Mississippi	S-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
	M-SCHIP	No benefit limits	No cost sharing	$8,000 during benefit period; $16,000 in a lifetime	No cost sharing	$8,000 during benefit period; $16,000 in a lifetime	No cost sharing

Table C.5 *(continued)*

State	Program Type	Inpatient Substance Abuse Treatment		Residential Substance Abuse Treatment		Outpatient Substance Abuse Treatment	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
Missouri	M-SCHIP	No benefit limits	No cost sharing	C-Star program; program not specified	Copay for intake evaluation and annual assessment 186 to 225% FPL - $5 copay 226 to 300% FPL - $10	No benefit limits	No cost sharing
Montana	S-SCHIP	21 days per benefit year (limit includes inpatient mental health treatment); $6,000 annual limit; lifetime maximum benefit of $12,000 (when this is met, the annual benefit may be reduced to $2,000); monetary limit includes outpatient substance abuse treatment (MT1)	>100% FPL - $25 copay	$6,000 annual limit; lifetime maximum benefit of $12,000 (when this is met, the annual benefit may be reduced to $2,000);monetary limit includes outpatient substance abuse treatment (MT1)	>100% FPL - $25 copay	$6,000 in a 12-month period; lifetime maximum benefit of $12,000 (when this is met, the annual benefit may be reduced to $2,000); monetary limit includes outpatient substance abuse treatment (MT1)	>100% FPL - $5 copay
Nebraska	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Nevada	S-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
New Hampshire	S-SCHIP	15 days per calendar year	No cost sharing	Service not covered	Service not covered	20 visits per calendar year	No cost sharing
	M-SCHIP (NH1)	Service not covered	Service not covered	Service not covered	Service not covered	Service not covered	Service not covered

Table C.5 *(continued)*

State	Program Type	Inpatient Substance Abuse Treatment		Residential Substance Abuse Treatment		Outpatient Substance Abuse Treatment	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
New Jersey	S-SCHIP (NJ1)	Plan B and C - No benefit limits Plan D - Inpatient detoxification only; rehab not covered	No cost sharing	Service not covered	Service not covered	Plan B and C - No benefit limits Plan D - Rehab not covered	Plan B and C - No cost sharing Plan D - $5 copay
	M-SCHIP	Covers acute care hospital only	No cost sharing	Service not covered	Service not covered	No limit if provided by a licensed practitioner	No cost sharing
New Mexico	M-SCHIP	No benefit limit	<185% FPL - No copay 185 to 235% FPL - $25 copay (NM1)	No benefit limit	<185% FPL - No copay 185 to 235% FPL - $25 copay (NM1)	No benefit limit	<185% FPL - No copay 185 to 235% FPL - $5 copay (NM1)
New York	S-SCHIP	30 days per calendar year (limit includes inpatient mental health care)	No cost sharing	30 days per calendar year (limit includes inpatient mental health care)	No cost sharing	60 days per calendar year (limit includes outpatient mental health care)	No cost sharing
	M-SCHIP	No benefit limit	No cost sharing	No benefit limit	No cost sharing	No benefit limit	No cost sharing
North Carolina	S-SCHIP	No benefit limits (b)	No cost sharing	No benefit limits (b)	No cost sharing	26 visits covered in plan year without prior approval; over 26 visits covered if approved in advance by the mental health case manager	No cost sharing
North Dakota	S-SCHIP	(c)	(c)	(c)	(c)	(c)	(c)
	M-SCHIP	No benefit limit	No cost sharing	No benefit limit	No cost sharing	No benefit limit	No cost sharing
Ohio	M-SCHIP	Services must be provided in a residential or other community-based setting	No cost sharing	Services must be provided in a residential or other community-based setting	No cost sharing	Provider must be certified by the Ohio Department of Alcohol and Drug Addiction Services	No cost sharing
Oklahoma	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing

Table C.5 *(continued)*

State	Program Type	Inpatient Substance Abuse Treatment		Residential Substance Abuse Treatment		Outpatient Substance Abuse Treatment	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
Oregon	S-SCHIP	Services must be provided by structured 24-hour supervised treatment and care facility	No cost sharing	Services must be provided by structured 24-hour supervised treatment and care facility	No cost sharing	Services must be provided in Office of Alcohol and Drug Abuse Programs (OADAP) approved facilities and meet OADAP approved treatment criteria	No cost sharing
Pennsylvania	S-SCHIP	7 days of treatment per admission; lifetime limit of 4 admissions	No cost sharing	30 days per year; lifetime limit of 90 days	No cost sharing	30 full session visits or equivalent partial visits per year; lifetime limit of 120 days	No cost sharing
Rhode Island	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
South Carolina	M-SCHIP	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing
South Dakota	S-SCHIP	(c)	(c)	(c)	(c)	(c)	(c)
South Dakota	M-SCHIP	45 days per year; days may be extended if determined medically necessary by Division of Drug and Alcohol, Department of Human Services (SD1)	No cost sharing	45 days in a 12-month period	No cost sharing	60 hours in a 12-month period	No cost sharing
Tennessee	M-SCHIP	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing
Texas	S-SCHIP	(c)	(c)	(c)	(c)	(c)	(c)
	M-SCHIP	Service not covered	Service not covered	Service not covered	Service not covered	Services must be provided by duly enrolled providers	No cost sharing

Table C.5 *(continued)*

State	Program Type	Inpatient Substance Abuse Treatment		Residential Substance Abuse Treatment		Outpatient Substance Abuse Treatment	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
Utah	S-SCHIP (UT1)	30 days per plan year (limit includes inpatient mental health care)	Plan A - No cost sharing Plan B - Patient pays 10% of stay for first 10 days, 50% for next 20 days	30 days per plan year (UT2)	Plan A - No cost sharing Plan B - Patient pays 10% of stay for first 10 days, 50% for next 20 days	30 visits per plan year (limit includes outpatient mental health care)	Plan A - $5 copay per visit Plan B - 50% coinsurance per visit
Vermont	S-SCHIP	No benefit limits (b)	No cost sharing	No benefit limits (b)	No cost sharing	No benefit limits	No cost sharing
Virginia	S-SCHIP	Benefit for pregnant women only (VA1)	No cost sharing	Benefit for pregnant women only; one course of treatment in a lifetime (VA1)	No cost sharing	26 visits per year; may be extended as medically necessary (VA2)	No cost sharing
Washington	S-SCHIP	Limited through the Division of Alcohol and Substance Abuse (limits not specified)	No cost sharing	Limited through the Division of Alcohol and Substance Abuse (limits not specified)	No cost sharing	No benefit limits	No cost sharing
West Virginia	S-SCHIP	30 days per year	No cost sharing	No benefit limits	No cost sharing	26 visits per year; may be extended as medically necessary	No cost sharing
	M-SCHIP	Pre-admission certification by PRO	No cost sharing	No benefit limits	No cost sharing	No benefit limits.	No cost sharing
Wisconsin	M-SCHIP	No benefit limits	No cost sharing (WI1)	No benefit limits	No cost sharing	No benefit limits	No cost sharing (WI1)
Wyoming	S-SCHIP	Service not covered	Service not covered	Service not covered	Service not covered	No benefit limits	No cost sharing

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations, Section 3.2.1 of the State Evaluation Framework.

(a) Service must be medically necessary.

(b) Prior approval required.

Table C.5 *(continued)*

(c) Program not implemented at time of title XXI State Evaluation.

AZ1 Only psychiatrists, psychologist, psychiatric nurse practitioners may bill independently for behavioral health services. Other behavioral health professionals and behavioral health technicians must be affiliated with a qualified agency, and services provided by these individuals must be billed through that agency.

CA1 Children with special needs receive services through CCS and CMH at no cost.

CT1 For outpatient substance abuse services, Connecticut offers supplemental coverage under Husky Plus.

FL1 Florida has three S-SCHIP programs: Healthy Kids, MediKids, and CMS. Healthy Kids covers children 5 - 19 years between 101 and 200% of poverty. (In some counties younger siblings may be covered in HealthyKids.) MediKids covers children from birth to age five; the income levels vary according to a child's age, but the threshold is 200% of poverty. CMS offers coverage for disabled children from birth to 19; the income levels vary according to a child's age, but the threshold is 200% of poverty.

FL2 In Florida Medicaid, MediKids, and CMS, outpatient substance abuse services must be provided by participating community health providers. A physician must provide hospital outpatient services.

GA1 Services furnished in a state-operated mental hospital are not covered. Services furnished in an Institution for Mental Diseases (IMD) are not covered.

IL1 Illinois has two S-SCHIP programs: KidCare Share and KidCare Premium. KidCare Share covers children between 134 and 150% of poverty; KidCare Premium covers children between 151 and 185% of poverty. The annual copayment maximum is $100 per family. Families with American Indian or Alaska Native children do not pay premiums or copays.

IL2 Federal funds are not claimed on the room and board portion for residential substance abuse treatment services.

IA1 Iowa's S-SCHIP program offers services under the Wellmark Plans (Wellmark Classic Blue (Indemnity) and Wellmark Unity Choice (HMO)) and the Iowa Health Solutions Health Plan (HMO).

KY1 The Medicaid provider network must provide all benefits. Primary care provider referrals are required for some services provided through managed care.

MA1 Massachusetts has three different S-SCHIP programs: Family Assistance Direct Coverage (FADC) is the state's separate S-SCHIP for children 1 to 18 years between 150 and 200% of poverty; Family Assistance Premium Assistance (FAPA) is an employer buy-in program for those with access to employer-sponsored (ESI) insurance between 150 and 200% of poverty; and CommonHealth (CH) is a program for disabled children between 150 and 200% of poverty. FAPA has cost sharing and benefit limits in accordance with the individual ESI policy.

MN1 The Minnesota State Medicaid Plan details the limitations applied to both Medicaid and S-SCHIP services; limitations may include prior authorization thresholds or define settings in which services must be provided.

MT1 Substance abuse benefit limits are combined for inpatient and outpatient treatment for alcoholism and drug addiction, excluding costs for medical detoxification. Costs for medical detoxification treatment are paid the same as any other illness and are not subject to the lifetime limits.

NH1 New Hampshire M-SCHIP program is for infants only.

NJ1 New Jersey has three S-SCHIP programs: Plans B, C and D. Plan B offers coverage to children in families with gross incomes between 133 and 150% of poverty; Plan C covers children between 151 and 200% of poverty; and Plan D covering children between 201 and 350% of poverty.

NM1 There is no copay for services through the Indian Health Service (IHS).

Table C.5 *(continued)*

SD1	Substance abuse services in South Dakota are covered under EPSDT.
UT2	Plan A applies to enrollees at or below 150% of poverty; Plan B applies to enrollees between 150 and 200% of poverty.
UT1	Residential treatment may be provided in lieu of inpatient care if the enrollee otherwise would be hospitalized for treatment of a mental illness or substance abuse.
VA1	Services offered in an Institution for Mental Diseases (IMD) are not covered; children in IMDs are not eligible for CMSIP.
VA2	There is no limit if outpatient mental health services are provided by a DMAS-enrolled mental health professional.
WI1	Wisconsin cost sharing is for adults only and is not required from those served through managed care.

TABLE C.6

BENEFIT LIMITS AND COST SHARING FOR THERAPY SERVICES UNDER SCHIP

State	Program Type	Physical Therapy		Speech Therapy		Occupational Therapy	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
Alabama	S-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Alaska	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Arkansas	M-SCHIP	4 units of evaluation (30 minutes each) per state fiscal year; maximum of 4 units of treatment (15 minutes each) per day; limits may be extended based on medical necessity	No cost sharing	4 units of evaluation (30 minutes each) per state fiscal year; maximum of 4 units of treatment (15 minutes each) per day; limits may be extended based on medical necessity	No cost sharing	4 units of evaluation (30 minutes each) per state fiscal year; maximum of 4 units of treatment (15 minutes each) per day; limits may be extended based on medical necessity	No cost sharing
Arizona	S-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
California	S-SCHIP (CA1)	60 consecutive calendar days (a)	$5 copay if done as outpatient; no copay if done as inpatient	60 consecutive calendar days (a)	$5 copay if done as outpatient. no copay if done as inpatient	60 consecutive calendar days (a)	$5 copay if done as outpatient.; no copay if done as inpatient
	M-SCHIP	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits
Colorado	S-SCHIP	30 visit limit on any combination of therapy services per diagnosis per benefit period	101 to 150% FPL - $2 copay; 151 to 185% FPL - $5 copay	30 visit limit on any combination of therapy services per diagnosis per benefit period	101 to 150% FPL - $2 copay; 151 to 185% FPL - $5 copay	30 visits limit on any combination of therapy services per diagnosis per benefit period	101 to 150% FPL - $2 copay; 151 to 185% FPL - $5 copay
Connecticut	S-SCHIP	Short term therapy (duration not specified) (CT1)	No cost sharing	Short term therapy (duration not specified)(CT1)	No cost sharing	Short term therapy (duration not specified) (CT1)	No cost sharing
	M-SCHIP	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits
Delaware	S-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing

TABLE C.6 *(continued)*

State	Program Type	Physical Therapy		Speech Therapy		Occupational Therapy	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
District of Columbia	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Florida	S-SCHIP (FL1)	Healthy Kids - 24 session within a 60 day period MediKids and CMS - No benefit limits (a)	Healthy Kids - $3 per visit MediKids and CMS -No copay	Healthy Kids - 24 session within a 60 day period MediKids and CMS - No benefit limits (a)	Healthy Kids - $3 per visit MediKids and CMS - No copay	Healthy Kids - 24 session within a 60 day period MediKids and CMS - No benefit limits (a)	Healthy Kids - $3 per visit MediKids and CMS - No copay
	M-SCHIP	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing
Georgia	S-SCHIP	1 hour per day up to ten hours per calendar month (with prior approval, this limit may be exceeded); only covered for children from 0 to 18 years (GA1)	No cost sharing	1 session per day up to ten sessions per month (with prior approval, these limits may be exceeded); only covered for children from 0 to 18 years (GA1)	No cost sharing	1 hour per day up to ten hours per calendar month (with prior approval, this limit may be exceeded); only covered for children from 0 to 18 years (GA1)	No cost sharing
Hawaii	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Idaho	M-SCHIP	100 visits per year	No cost sharing	250 sessions per calendar year	No cost sharing	30 hours per week combined with developmental therapy	No cost sharing
Illinois	S-SCHIP (IL1)	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Indiana	S-SCHIP	(c)	(c)	(c)	(c)	(c)	(c)
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing

TABLE C.6 *(continued)*

State	Program Type	Physical Therapy		Speech Therapy		Occupational Therapy	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
Iowa	S-SCHIP (IA1)	No benefit limits	No cost sharing	No benefit limits	No cost sharing	Wellmark Plan- Services only to treat the upper extremities, (the arms from the shoulders to the fingers); occupational therapy supplies are excluded Iowa Solutions Plan - no benefit limits	No cost sharing
	M-SCHIP	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing
Kansas	S-SCHIP	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing
Kentucky	S-SCHIP	No benefit limits (KY1)	No cost sharing	No benefit limits (KY1)	No cost sharing	Service not covered (KY2)	Service not covered (KY2)
	M-SCHIP	No benefit limits (KY1)	No cost sharing	No benefit limits (KY1)	No cost sharing	No benefit limits	No cost sharing
Louisiana	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Maine	S-SCHIP	2 hours per day	No cost sharing	No benefit limits	No cost sharing	2 hours per day	No cost sharing
	M-SCHIP	2 hours per day	No cost sharing	No benefit limits	No cost sharing	2 hours per day	No cost sharing
Maryland	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Massachusetts	S-SCHIP (MA1)	FADC and CH - No benefit limits FAPA - 90 days per condition and only when needed to improve ability to perform ADL (MA2)	No cost sharing	FADC and CH - No benefit limits FAPA - 90 days per condition and only when needed to improve ability to perform ADL (MA2)	No cost sharing	FADC and CH - No benefit limits FAPA - 90 days per condition and only when needed to improve ability to perform ADL (MA2)	No cost sharing
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Michigan	S-SCHIP	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing
	M-SCHIP	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing
Minnesota	M-SCHIP	Limitations apply (not specified) (MN1)	No cost sharing	Limitations apply (not specified) (MN1)	No cost sharing	Limitations apply (not specified) (MN1)	No cost sharing

TABLE C.6 *(continued)*

State	Program Type	Physical Therapy		Speech Therapy		Occupational Therapy	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
Mississippi	S-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Missouri	M-SCHIP	No benefit limits	Copays for evaluations 186 to 225% FPL - $5 copay 226 to 300% FPL - $10 copay	No benefit limits	Copays for evaluations 186 to 225% FPL - $5 copay 226 to 300% FPL - $10 copay	No benefit limits	Copays for evaluations 186 to 225% FPL - $5 copay 226 to 300% FPL - $10 copay
Montana	S-SCHIP	Service not covered	Service not covered	Service not covered	Service not covered	Service not covered	Service not covered
Nebraska	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Nevada	S-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
New Hampshire	S-SCHIP	24 combined visits of physical or occupational therapy	$5 copay	24 visits per year	$5 copay	24 combined visits of physical or occupational therapy	$5 copay
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
New Jersey	S-SCHIP (NJ1)	Plan B and C - 60 day limit per year Plan D - 60 day consecutive period per incident; limited to treatment of non-chronic conditions and acute illnesses	Plan B and C - No cost sharing Plan D - $5 copay	Plan B and C - 60 day limit per year Plan D - 60 day consecutive period per incident; limited to treatment of non-chronic conditions and acute illnesses	Plan B and C - No cost sharing Plan D - $5 copay	Plan B and C - 60 day limit per year Plan D - 60 day consecutive period per incident; limited to treatment of non-chronic conditions and acute illnesses	Plan B and C - No cost sharing Plan D - $5 copay
	M-SCHIP	Covered as provided by home health agency, clinic, nursing facility, hospital, or physician's office	No cost sharing	Covered as provided by home health agency, clinic, nursing facility, hospital, or physician's office	No cost sharing	Covered as provided by home health agency, clinic, nursing facility, hospital, or physician's office	No cost sharing

TABLE C.6 *(continued)*

State	Program Type	Physical Therapy		Speech Therapy		Occupational Therapy	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
New Mexico	M-SCHIP	No benefit limits	<185% of FPL - No copay 185 to 235% of FPL - $5 copay (NM1)	No benefit limits	<185% of FPL - No copay 185 to 235% of FPL - $5 copay (NM1)	No benefit limits	<185% of FPL - No copay 185 to 235% of FPL - $5 copay (NM1)
New York	S-SCHIP	Short term (duration not specified)	No cost sharing	Condition must be amenable to significant clinical improvement within a 2 month period	No cost sharing	Short term (duration not specified)	No cost sharing
	M-SCHIP	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits	Did not report on M-SCHIP benefits
North Carolina	S-SCHIP	Prior approval required when given in the home	No cost sharing	Prior approval required when given in the home or office	No cost sharing	Prior approval required when given in the home	No cost sharing
North Dakota	S-SCHIP	(c)	(c)	(c)	(c)	(c)	(c)
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Ohio	M-SCHIP	48 modalities per 12-month period	No cost sharing	No benefit limits	No cost sharing	Only covered as components of the home health and outpatient hospital benefits	No cost sharing
Oklahoma	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Oregon	S-SCHIP	Services must be as described in the OMAP Physical Therapy guide and in accordance with the plan of treatment of health conditions listed on the OHP Prioritized List (OR1)	No cost sharing	Services must be as described in the Speech-Language, Audiology & Hearing Aid Services guide and in accordance with the plan of treatment of health conditions listed on the OHP Prioritized List (OR1)	No cost sharing	Services must be as described in the Physical and Occupational Therapy Service guide and in accordance with the plan of treatment of health conditions listed on the OHP Prioritized List (OR1)	No cost sharing

TABLE C.6 *(continued)*

State	Program Type	Physical Therapy		Speech Therapy		Occupational Therapy	
		Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing	Benefit Limits	Cost Sharing
Pennsylvania	S-SCHIP	60 visits per year	No cost sharing	60 visits per year	No cost sharing	60 visits per year	No cost sharing
Rhode Island	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
South Carolina	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
South Dakota	S-SCHIP	(c)	(c)	(c)	(c)	(c)	(c)
	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Tennessee	M-SCHIP	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing	No benefit limits (a)	No cost sharing
Texas	S-SCHIP	(c)	(c)	(c)	(c)	(c)	(c)
	M-SCHIP	Must be physician prescribed	No cost sharing	Must be physician prescribed	No cost sharing	Must be physician prescribed	No cost sharing
Utah	S-SCHIP (UT1)	16 visit limit per year; applies to any combination of physical, occupational, speech, or chiropractic visits	Plan A - $5 copay per visit Plan B - $10 copay per visit	16 visit limit per year; applies to any combination of physical, occupational, speech, or chiropractic visits	Plan A - $5 copay per visit Plan B - $10 copay per visit	16 visit limit per year; applies to any combination of physical, occupational, speech, or chiropractic visits	Plan A - $5 copay per visit Plan B - $10 copay per visit
Vermont	S-SCHIP	Prior approval after first 4 months	No cost sharing	Prior approval after first 4 months	No cost sharing	Prior approval after first 4 months	No cost sharing
Virginia	S-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Washington	S-SCHIP	Limited under fee-for-service (limits not specified)	No cost sharing	Limited under fee-for-service (limits not specified)	No cost sharing	Limited under fee-for-service (limits not specified)	No cost sharing
West Virginia	S-SCHIP	20 visits in a 12-month coverage period; must be ordered by a physician	No cost sharing	$1,000 per year; must be ordered by a physician	No cost sharing	$1,000 per year ; therapy must be ordered by a physician; further therapy must be approved in advance.	No cost sharing
	M-SCHIP	Frequency and occurrence limits; limits not specified	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Wisconsin	M-SCHIP	No benefit limits	No cost sharing	No benefit limits	No cost sharing	No benefit limits	No cost sharing
Wyoming	S-SCHIP	No benefit limits	No cost sharing	Service not covered	Service not covered	Service not covered	Service not covered

TABLE C.6 *(continued)*

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations, Section 3.2.1 of the State Evaluation Framework.

(a) Service must be medically necessary.

(b) Prior approval required.

(c) Program not implemented at time of title XXI State Evaluation.

CA1 Services provided to children with special needs through CCS and CMH are provided at no cost.

CT1 For physical, speech, and occupational therapy, Connecticut offers supplemental coverage under Husky Plus.

FL1 Florida has three S-SCHIP programs: Healthy Kids, MediKids, and CMS. Healthy Kids covers children 5 - 19 years between 101 and 200% of poverty. (In some counties younger siblings may be covered in HealthyKids.) MediKids covers children from birth to age five; the income levels vary according to a child's age, but the threshold is 200% of poverty. CMS offers coverage for disabled children from birth to 19; the income levels vary according to a child's age, but the threshold is 200% of poverty.

GA1 Written prior approval is required for medically necessary Children's Intervention Services once the annual service limitations listed in the Policy and Procedure Manual have been reached. An individualized family service plan is required to document medical necessity for amount, duration, and scope of services.

IL1 Illinois has two S-SCHIP programs: KidCare Share and KidCare Premium. KidCare Share covers children between 134 and 150% of poverty; KidCare Premium covers children between 151 and 185% of poverty. The annual copayment maximum is $100 per family. Families with American Indian or Alaska Native children do not pay premiums or copays.

IA1 Iowa's S-SCHIP program offers services under the Wellmark Plans (Wellmark Classic Blue (Indemnity) and Wellmark Unity Choice (HMO)) and the Iowa Health Solutions Health Plan (HMO).

KY1 The Medicaid provider network must provide all benefits. Primary care provider referrals are required for some services provided through managed care.

KY2 Kentucky's S-SCHIP program does not cover EPSDT Special Services.

MA1 Massachusetts has three different S-SCHIP programs: Family Assistance Direct Coverage (FADC) is the state's separate S-SCHIP for children 1 to 18 years between 150 and 200% of poverty; Family Assistance Premium Assistance (FAPA) is an employer buy-in program for those with access to employer-sponsored (ESI) insurance between 150 and 200% of poverty; and CommonHealth (CH) is a program for disabled children between 150 and 200% of poverty. FAPA has cost sharing and benefit limits in accordance with the individual ESI policy.

MA2 In the premium assistance plan, physical, speech, and occupational therapy are covered up to 90 days per condition and only when needed to improve ability to perform activities of daily living (ADL). In the opinion of the PCP, significant improvement to a patient's condition within 90 days must be likely. Children under 3 are exempted from the 90 day limit; therapy as part of the home health care benefit is unlimited.

MN1 The Minnesota State Medicaid Plan details the limitations applied to both Medicaid and S-SCHIP services; limitations may include prior authorization thresholds or define settings in which services must be provided.

NJ1 New Jersey has three S-SCHIP programs: Plans B, C and D. Plan B offers coverage to children in families with gross incomes between 133 and 150% of poverty; Plan C covers children between 151 and 200% of poverty; and Plan D covering children between 201 and 350% of poverty.

TABLE C.6 *(continued)*

NM1 There is no copay for services through the Indian Health Service (IHS).

OR1 OMAP will reimburse for the lowest level of service that meets the medical need. Therapy is based on a prescribing practitioner's written order and a therapy treatment with goals and objectives developed from an evaluation/reevaluation. The therapy regimen will be taught to the patient, family, and/or caregiver to assist in the achievement of the goals and objectives. Therapy that becomes maintenance is not a covered service.

UT1 Plan A applies to enrollees at or below 150% of poverty; Plan B applies to enrollees between 150 and 200% of poverty.

TABLE C.7

SIMULATED ANNUAL OUT-OF-POCKET EXPENDITURES FOR CHILDREN ENROLLED IN SCHIP IN THREE HYPOTHETICAL FAMILY SCENARIOS, BY POVERTY LEVEL: COVERED SERVICES ONLY

		Total Out-Of-Pocket Expenditures: Covered Services Only[a]									Out-Of-Pocket Expenditures as a Percentage of Income: Covered Services Only[a]								
		Family 1[b]			Family 2[c]			Family 3[d]			Family 1[b]			Family 2[c]			Family 3[d]		
State	Program Type	150% FPL	200% FPL	250% FPL	150% FPL	200% FPL	250% FPL	150% FPL	200% FPL	250% FPL	150% FPL	200% FPL	250% FPL	150% FPL	200% FPL	250% FPL	150% FPL	250% FPL	250% FPL
Alabama	COMBO	110	130	--	110	223	--	110	186	--	0.43	0.38	--	0.43	0.65	--	0.43	0.55	--
Alaska	M-SCHIP	0	0	--	0	0	--	0	0	--	0.00	0.00	--	0.00	0.00	--	0.00	0.00	--
Arizona	S-SCHIP	0	0	--	20	20	--	5	5	--	0.00	0.00		0.08	0.06	--	0.02	0.01	--
California	COMBO	208	236	236	418	466	466	408	456	456	0.81	0.69	0.55	1.63	1.37	1.09	1.60	1.34	1.07
Colorado	S-SCHIP	192	--	--	323	--	--	268	--	--	0.75	--	--	1.26	--	--	1.05	--	--
Connecticut	COMBO	DNR	20	648	DNR	265	875	DNR	408	1,008	DNR	0.06	1.52	DNR	0.78	2.05	DNR	1.20	2.36
Delaware	S-SCHIP	180	300	--	180	300	--	180	300	--	0.70	0.88	--	0.70	0.88	--	0.70	0.88	--
Florida	COMBO	204	192	--	385	385	--	331	331	--	0.80	0.56	--	1.51	1.13	--	1.29	0.97	--
Georgia	S-SCHIP	180	180	--	180	180	--	180	180	--	0.70	0.53	--	0.70	0.53	--	0.70	0.53	--
Illinois	COMBO	20	--	--	82	--	--	100	--	--	0.08	--	--	0.32	--	--	0.39	--	--
Iowa	COMBO	240	--	--	340	--	--	265	--	--	0.94	--	--	1.33	--	--	1.04	--	--
Kansas	S-SCHIP	0	180	--	0	180	--	0	180	--	0.00	0.53	--	0.00	0.53	--	0.00	0.53	--
Maine	COMBO	120	360	--	120	360	--	120	360	--	0.47	1.06	--	0.47	1.06	--	0.47	1.06	--
Massachusetts	COMBO	240	240	--	240	240	--	240	240	--	0.94	0.70	--	0.94	0.70	--	0.94	0.70	--
Michigan	COMBO	60	60	--	60	60	--	60	60	--	0.23	0.18	--	0.23	0.18	--	0.23	0.18	--
Mississippi	COMBO	20	20	--	100	100	--	45	45	--	0.08	0.06	--	0.39	0.29	--	0.18	0.13	--
Missouri	M-SCHIP	0	20	876	100	145	1241	0	30	981	0.00	0.06	2.06	0.39	0.43	2.91	0.00	0.09	2.30
Montana	S-SCHIP	43	--	--	166	--	--	215	-	--	0.17	--	--	0.65	--	--	0.84	--	--
Nevada	M-SCHIP	40	200	--	40	200	--	40	200	--	0.16	0.59	--	0.16	0.59	--	0.16	0.59	--
New Hampshire	COMBO	--	500	530	--	930	930	--	690	690	--	1.47	1.24	--	2.73	2.18	--	2.02	1.62
New Jersey	COMBO	0	210	400	5	354	780	0	291	1,030	0.00	0.62	0.94	0.02	1.04	1.83	0.00	0.85	2.42
New Mexico	M-SCHIP	-	40	--	-	279	--	-	207	--	-	0.12	--	-	0.82	--	-	0.61	--
New York	COMBO	216	--	--	216	--	--	216	--	--	0.84	--	--	0.84	--	--	0.84	--	--
North Carolina	S-SCHIP	0	120	--	0	382	--		276	--	0.00	0.35	--	0.00	1.12	--	0.00	0.81	--
Rhode Island[e]	M-SCHIP	0	162	162	0	162	162	0	162	162	0.00	0.48	0.38	0.00	0.48	0.38	0.00	0.48	0.38
Rhode Island[f]	M-SCHIP	0	20	28	0	94	94	0	72	72	0.00	0.06	0.07	0.00	0.28	0.22	0.00	0.21	0.17
Utah	S-SCHIP	48	60	--	274	848	--	202	994	--	0.19	0.18	--	1.07	2.49	--	0.79	2.91	--
Vermont	S-SCHIP	240	--	--	240	--	--	240	--	--	0.94	--	--	0.94	--	--	0.94	--	--
Washington	S-SCHIP	270	260	270	445	445	445	345	345	345	1.06	0.76	0.63	1.74	1.30	1.04	1.35	1.01	0.81
Wisconsin	M-SCHIP	60	75	--	60	75	--	60	75	--	0.23	0.22	--	0.23	0.22	--	0.23	0.22	--

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations, Sections 3.2.1, 3.3.1, and 3.3.2 of the State Evaluation Framework.

NOTE: The type of SCHIP program is as of March 31, 2001. The state evaluations generally present program characteristics as of September 30, 1999. The 2000 Federal poverty level (FPL) for a family of four is a gross annual income of $17,050 in the contiguous 48 states and D.C., $21,320 in Alaska, and $19,610 in Hawaii.

[a] This simulation includes only the services that are covered under SCHIP plans. Alabama does not cover DME; Colorado does not cover dental; Delaware does not cover dental; Florida does not cover dental; Mississippi covers restorative dental work only if it results from an accident; Montana does not cover DME, OT, PT, or speech therapy; New Jersey does not cover DME or restorative dental work for children at 250 percent FPL; Utah does not cover eyeglasses.

Table C.7 *(continued)*

[b] Family 1 has two children, ages 7 and 10, without chronic conditions. Our analysis assumes that each child would have 2 physician office visits, 1 preventive care visit, 1 preventive dental visit, 1 restorative dental visit, 2 30-day generic prescriptions, and 1 30-day brand name prescription.

[c] Family 2 consists of one 7-year-old child without a chronic condition and one 10-year-old child with a chronic neuromuscular condition. The 7-year-old child would have the same utilization pattern described above for Family 1. The 10-year-old with a chronic neuromuscular condition would have 6 physician office visits, 2 preventive care visits, 4 non-emergent ER visits, 1 preventive dental visit, 1 restorative dental visit, 10 physical therapy sessions, 5 occupational therapy sessions, 5 speech therapy sessions, and 1 vision exam. We also assume the child would have 12 30-day generic prescriptions and 12 30-day brand name prescriptions. Our analysis also assumes the family would purchase 1 piece of durable medical equipment, and a pair of eyeglasses.

[d] Family 3 consists of one 7-year-old child without a chronic condition and one 10-year-old child with an acute psychiatric disorder. The 7-year-old child would have the same utilization pattern as a child in Family 1. The 10-year-old child with an acute psychiatric disorder would have 4 physician office visits, 1 preventive care visit, 1 non-emergent ER visit, 1 preventive dental visit, 1 restorative dental visit, and 20 mental health visits. We also assume the child would have 9 30-day generic prescriptions and 9 30-day brand name prescriptions.

[e] Assumes families over 185% FPL chose the premium option.

[f] Assumes families over 185% FPL chose the copayment option.

DNR = Did not report.
-- = Not covered by SCHIP.

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TABLE C.8

SIMULATED ANNUAL OUT-OF-POCKET EXPENDITURES FOR CHILDREN ENROLLED IN SCHIP IN THREE HYPOTHETICAL FAMILY SCENARIOS, BY POVERTY LEVEL: COVERED AND NON-COVERED SERVICES

		Total Out-Of-Pocket Expenditures: Covered and Non-Covered Services[a]									Out-Of-Pocket Expenditures as a Percentage of Income: Covered and Non-Covered Services[a]								
		Family 1[b]			Family 2[c]			Family 3[d]			Family 1[b]			Family 2[c]			Family 3[d]		
State	Program Type	150% FPL	200% FPL	250% FPL	150% FPL	200% FPL	250% FPL	150% FPL	200% FPL	250% FPL	150% FPL	200% FPL	250% FPL	150% FPL	200% FPL	250% FPL	150% FPL	200% FPL	250% FPL
Alabama	COMBO	110		--	1,610	1,723	--	110	186	--	0.43	0.38	--	6.30	5.05	--	0.43	0.55	--
Alaska	M-SCHIP	0	0	--	0	0	--	0	0	--	0.00	0.00	--	0.00	0.00	--	0.00	0.00	--
Arizona	S-SCHIP	0	0	--	20	20	--	5	5	--	0.00	0.00	--	0.08	0.06	--	0.02	0.01	--
California	COMBO	208	236	236	418	466	466	408	456	456	0.81	0.69	0.55	1.63	1.37	1.09	1.60	1.34	1.07
Colorado	S-SCHIP	392	--	--		--	--	468	--	--	1.53	--	--	2.04	--	--	1.83	--	--
Connecticut	COMBO	DNR	20	648	DNR	265	875	DNR	408	1,008	DNR	0.06	1.52	DNR	0.78	2.05	DNR	1.20	2.36
Delaware	S-SCHIP	380	500	--	380	500	--	380	500	--	1.49	1.47	--	1.49	1.47	--	1.49	1.47	--
Florida	COMBO	404	392	--	585	585	--	531	531	--	1.58	1.15	--	2.29	1.72	--	2.08	1.56	--
Georgia	S-SCHIP	180	180	--	180	180	--	180	180	--	0.70	0.53	--	0.70	0.53	--	0.70	0.53	--
Illinois	COMBO	20	--	--	82	--	--	100	--	--	0.08	--	--	0.32	--	--	0.39	--	--
Iowa	COMBO	240	--	--	340	--	--	265	--	--	0.94	--	--	1.33	--	--	1.04	--	--
Kansas	S-SCHIP	0	180	--	0	180	--	0	180	--	0.00	0.53	--	0.00	0.53	--	0.00	0.53	--
Maine	COMBO	120	360	--	120	360	--	120	360	--	0.47	1.06	--	0.47	1.06	--	0.47	1.06	--
Massachusetts	COMBO	240	240	--	240	240	--	240	240	--	0.94	0.70	--	0.94	0.70	--	0.94	0.70	--
Michigan	COMBO	60	60	--	60	60	--	60	60	--	0.23	0.18	--	0.23	0.18	--	0.23	0.18	--
Mississippi	COMBO	20	20	--	100	100	--	45	45	--	0.08	0.06	--	0.39	0.29	--	0.18	0.13	--
Missouri	M-SCHIP	0	20	876	100	145	1,241	0	30	981	0.00	0.06	2.06	0.39	0.43	2.91	0.00	0.09	2.30
Montana	S-SCHIP	43	--	--	2,666	--	--	215	--	--	0.17	--	--	10.42	--	--	0.84	--	--
Nevada	M-SCHIP	40	200	--	40	200	--	40	200	--	0.16	0.59	--	0.16	0.59	--	0.16	0.59	--
New Hampshire	COMBO	--	500	530	--	930	930	--	690	690	--	1.47	1.24	--	2.73	2.18	--	2.02	1.62
New Jersey	COMBO	0	210	500	5	354	2,380	0	291	1,130	0.00	0.62	1.17	0.02	1.04	5.58	0.00	0.85	2.65
New Mexico	M-SCHIP	0	40	--	0	279	--	0	207	--	--	0.12	--	--	0.82	--	--	0.61	--
New York	COMBO	216	--	--	216	--	--	216	--	--	0.84	--	--	0.84	--	--	0.84	--	--
North Carolina	S-SCHIP	0	120	--	0	382	--	0	276	--	0.00	0.35	--	0.00	1.12	--	0.00	0.81	--
Rhode Island[e]	M-SCHIP	0	162	162	0	162	162	0	162	162	0.00	0.48	0.38	0.00	0.48	0.38	0.00	0.48	0.38
Rhode Island[f]	M-SCHIP	0	20	28	0	94	94	0	72	72	0.00	0.06	0.07	0.00	0.28	0.22	0.00	0.21	0.17
Utah	S-SCHIP	48	60	--	374	948	--	202	994	--	0.19	0.18	--	1.46	2.78	--	0.79	2.91	--
Vermont	S-SCHIP	240	--	--	240	--	--	240	--	--	0.94	--	--	0.94	--	--	0.94	--	--
Washington	S-SCHIP	270	260	270	445	445	445	345	345	345	1.06	0.76	0.63	1.74	1.30	1.04	1.35	1.01	0.81
Wisconsin	M-SCHIP	60	75	--	60	75	--	60	75	--	0.23	0.22	--	0.23	0.22	--	0.23	0.22	--

SOURCE: Mathematica Policy Research analysis of title XXI State Evaluations, Sections 3.2.1, 3.3.1, and 3.3.2 of the State Evaluation Framework.

NOTE: The type of SCHIP program is as of March 31, 2001. The state evaluations generally present program characteristics as of September 30, 1999. The 2000 Federal poverty level for a family of four is a gross annual income of $17,050 in the contiguous 48 states and D.C., $21,320 in Alaska, and $19,610 in Hawaii.

TABLE C.8 *(continued)*

[a] Our analysis simulates out-of-pocket expenditures for services that are covered under SCHIP plans, as well as services that are not covered by SCHIP plans. Alabama does not cover DME; Colorado does not cover dental; Delaware does not cover dental; Florida does not cover dental; Mississippi covers restorative dental work only if it results from an accident; Montana does not cover DME, OT, PT, or speech therapy; New Jersey does not cover DME or restorative dental work at 250% FPL; Utah does not cover eyeglasses. We made the following assumptions about the costs of services when they were not covered: (1) dental services and vision services would cost $50 per visit; (2) eyeglasses would cost $100; (3) DME, $1,500; and (4) occupational therapy, physical therapy, and speech therapy, $50 per session.

[b] Family 1 has two children, ages 7 and 10, without chronic conditions. Our analysis assumes that each child would have 2 physician office visits, 1 preventive care visit, 1 preventive dental visit, 1 restorative dental visit, 2 30-day generic prescriptions, and 1 30-day brand name prescription.

[c] Family 2 consists of one 7-year-old child without a chronic condition and one 10-year-old child with a chronic neuromuscular condition. The 7-year-old child would have the same utilization pattern as a child in Family 1. The 10-year-old with a chronic neuromuscular condition would have 6 physician office visits, 2 preventive care visits, 4 non-emergent ER visits, 1 preventive dental visit, 1 restorative dental visit, 10 physical therapy sessions, 5 occupational therapy sessions, 5 speech therapy sessions, and 1 vision exam. We also assume the child would have 12 30-day generic prescriptions and 12 30-day brand name prescriptions. Our analysis also assumes the family would purchase 1 piece of durable medical equipment, and a pair of eyeglasses.

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